



**Standards and Guidelines for
Physician Practice Connections[®]—
Patient-Centered Medical Home
(PPC-PCMH[™])**

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Overview

The Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™) is a modification of 2006 Physician Practice Connections (PPC). The PPC-PCMH version of PPC reflects the input of primary care specialty societies and others on how to use the 2006 PPC to assess whether physician practices are functioning as medical homes.

Creating the PPC-PCMH as an approach to care is a response to the crisis in primary care, with far fewer physicians choosing careers in primary care (e.g., general internal medicine; family medicine; pediatrics; and in some formulations, obstetrics and gynecology). In addition, surveys indicate that physicians in primary care are disillusioned and considering early retirement or career change. Research by Barbara Starfield and others links higher ratios of primary care compared with specialties as having higher quality and lower costs (both in the United States and in international comparisons) of primary care.

Joint Principles of the PPC-PCMH

While early work on the medical home concept was done by pediatricians and focused on care of children with special needs, the concepts embedded in the Patient Centered Medical Home were further developed by a collaboration of the American College of Physicians (ACP), the American Academy of Family Practice (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA). NCQA provided input related to our work on the PPC and a Commonwealth Fund grant to define “patient-centeredness.” The joint principles, created and supported by ACP, AAFP, AAP and AOA, define the following key characteristics of the PCMH.

Personal physician—Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice—The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation—The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services and end of life care.

Care is coordinated or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home.

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient’s family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision making and feedback is sought to ensure patients’ expectations are being met.
- Information technology (IT) is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. While aspiring to improve patient care, the four primary care groups envision implementation of the PCMH as linked to more rational (and higher) payment for primary care, which is in very fragile status in the U.S. The four primary care groups, aided by others, have held discussions with employers, health plans and the federal government to encourage the development of PCMH implementation/demonstration programs. In concert with the joint principles, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

To achieve Recognition as a Patient-Centered Medical Home by meeting the NCQA PPC-PCMH standards, practices will attest to the 2007 Joint Principles of the Patient-Centered Medical Home of the AAFP, the AAP, the ACP and the AOA, as seen below. Practices apply for Recognition with the understanding that the PPC-PCMH standards assess many of the ways in which the practice functions as a patient-centered medical home. Functioning as a patient-centered medical home requires an approach beyond the areas assessed by the PPC-PCMH standards. The concept of the medical home and how to operationalize it is evolving and will result in future versions of the Joint Principles and PPC-PCMH.

NCQA developed the PPC-PCMH to evaluate the extent to which practices are Recognized as medical homes. During 2008, demonstration programs around the country will evaluate PCMHs to answer the following questions:

- How many practices can—and will—achieve Recognition?
- What quality and cost outcomes are associated with PCMHs?
- What are appropriate payment mechanisms for compensating PCMHs?

Demonstration practices will enhance and test PCMH care systems and submit documentation of their experience with the systems. NCQA will collect, analyze and report on PPC-PCMH results. Health plans, researchers, NCQA and others will evaluate the effectiveness of PPC-PCMH as tool for evaluating the quality and resource use of patient-centered medical homes. NCQA also will assess the need for changes in PPC 2006. We anticipate that recommended changes to PPC-PCMH and PPC 2006 will be merged into a single revision of PPC.

Why PPC-PCMH?

The Current Environment

In the private sector A number of groups have formed to support and promote the concept of the PCMH, most notably the purchaser-led Patient-Centered Primary Care Collaborative (PCPCC), which has been active with federal legislators. In addition, most national insurers and some regional insurers have expressed interest in the concept and have been in discussions with the physician specialty societies and NCQA.

Given the shortage of primary care physicians in many areas of the country, health plans are interested in attracting and retaining primary care physicians and in supporting their ability to coordinate care for patients—if it improves quality and reduces costs. There is insufficient data on the impact of resource use of PCMH practices. If there is a commitment to greater reimbursement for PCMHs, plans and employers want to see improved quality of care and demonstrable cost savings.

In the public sector Legislation requires the Centers for Medicare & Medicaid Services (CMS) to implement and evaluate a Medicare PCMH demonstration. A number of state Medicaid programs are also considering some type of patient-centered medical home demonstration.

The Historical Perspective

The 2001 Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001), is a major source of inspiration for NCQA and for PPC in particular. Crossing the Quality Chasm examines the current state of health care quality and articulates a new vision for health care in the U.S. The report proposes six major aims for a quality health care system—specifically, health care should be safe, effective, patient-centered, timely, efficient and equitable. Improving the systems that support health care is key to achieving these aims. To drive health care to change in this direction, the report challenges employers and other purchasers to reward quality in the way that they purchase health care. Bridges to Excellence (BTE) and other reward programs are beginning to do that.

A follow-up report from the IOM, *Building a Better Delivery System: A New Engineering/ Health Care Partnership* (IOM, 2005) further describes the “underinvestment in information and communications technologies” that could help make health care more safe, efficient and effective. The report calls for greater collaboration between health care and engineering to solve these problems, and for public and private entities to accelerate the development of the National Health Information Infrastructure.

Crossing the Quality Chasm: 10 Simple Rules for the 21st Century Health Care System

Crossing the Quality Chasm put forth "10 Simple Rules for the 21st Century Health Care System" to guide the redesign of the health care system. These rules underlie PPC and describe a system different from most health care today.

1. *Care based on continuous healing relationships.* Patients should receive care whenever they need it and in many forms, not just face-to-face visits.
2. *Customization based on patient needs and values.* The system of care should meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. *The patient as the source of control.* Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.
4. *Shared knowledge and the free flow of information.* Patients should have unfettered access to their own medical information and to clinical knowledge.
5. *Evidence-based decision making.* Patients should receive care based on the best available scientific knowledge.
6. *Safety as a system property.* Patients should be safe from injury caused by the care system.
7. *The need for transparency.* The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice and patient satisfaction.
8. *Anticipation of needs.* The health system should anticipate patient needs, rather than simply reacting to events.
9. *Continuous decrease in waste.* The health system should not waste resources or patient time.
10. *Cooperation among clinicians.* Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Crossing the Quality Chasm encourages focus on a finite number of chronic conditions that account for a large percentage of health care expenses in the U.S., and urges greater investment in and rewards for IT infrastructure to support evidence-based care. PPC brings together a focus on chronic care, with rewards for IT to support evidence-based care.

Specifically, the report cites an important body of work supporting the need for improved health care systems: the Model for Effective Chronic Illness Care, developed at HealthPartners in Minnesota and at Group Health Cooperative of Puget Sound (Bodenheimer, Wagner and Grumbach, 2002). Essential components of the model include clinical information systems that provide decision support for practitioners and prepared, proactive teams that offer self-management support to informed patients. Research shows that these systems produce effective, evidence-based care for people with chronic conditions. The Chronic Care Model spawned research done by NCQA funded by the Robert Wood Johnson Foundation, the development of survey-based measures to assess the presence of the elements of the model. These measures are incorporated into the PPC standards.

Other research shows that the components of the Chronic Care Model are not widely employed, despite compelling evidence of their usefulness. A major survey of large medical practices across the country assessed the presence of 16 care-management processes: 4 processes (disease registries, clinical guideline reminders, feedback to physicians and case management) used in treating each of four chronic conditions (diabetes, asthma, congestive heart failure and depression). Of the ideal 16 processes, the average number used was 5 (Casalino et al, 2002). This study also found that the more external incentives medical groups had, including financial incentives and public reporting, the more care processes they used.

The Consumer Perspective

At the same time that health services research is showing, ever more sharply, the importance of having systems in place to support quality health care, consumers seek to experience the benefits that follow from effective systems. Consumer research shows that consumers perceive many of the same shortcomings in the health care system. Moreover, patients value the kind of well-organized and coordinated experience with doctors that can result from good systems of care, and appreciate the value of evidence-based medicine.

Research has found that consumers are interested in systematic care and follow-up, when given the opportunity to evaluate them. In 2001, NCQA completed a review of the literature on consumer preferences around quality of physician care (NCQA, 2001) for a series of focus groups. A number of studies have shown that when asked what is important in a doctor, consumers first mention the physician's ability to communicate and show a caring attitude (Robinson and Brodie, 1997). When information on quality of care is put in a proper context, additional aspects come out.

A specific study of consumers' needs as ambulatory patients was done by the Picker Institute, and found a wider range of consumer needs than is customarily expected. The study queried consumers in focus groups on their views about what constitutes quality care, what types of information they need to make health care choices and what some of the obstacles were that they faced in obtaining useful information. It identified access and coordination of care, information, communication, appropriate education, support and alleviation of fear and anxiety as needs of ambulatory patients. Additional needs included patient experiences with specific procedures of care, such as assistance with tests and follow-up information (Edgman-Levitan and Cleary, 1996).

Consumers also perceive the gap between the ideal and the actual in medical practice. The Procter & Gamble Healthcare Consumer Institute conducted a Consumer Satisfaction and Loyalty Study (Walker, 2001; Procter & Gamble, 2002; Procter & Gamble, 2005), involving over 10,000 respondents across ages, geographic areas, income levels, ethnic backgrounds, genders and self-reported health status levels. The study measured characteristics that were most important to patients about doctors, how their doctors performed on those characteristics and gaps between values and performance.

Procter & Gamble's analysis indicated 12 "Big Opportunities": gaps between importance and performance. Among them are areas covered in the PPC standards.

- Staff/doctor returns calls in a timely manner
- Staff/doctor follows up with a phone call
- The doctor is familiar with the patient's medical history.
- The doctor is good at diagnosing and treating any problem (Procter & Gamble, 2005).

Consumers thus expressed unmet needs that, in the future, physicians could fulfill with better systems, information and processes to make knowledge more readily available.

PPC-PCMH Development

Development process	NCQA staff worked closely with leaders of the four specialty societies (ACP, AAFP, AAP, AOA) and other interested stakeholders to develop PPC-PCMH. Each organization supports this version as the tool to use to Recognize practices as medical homes in PCMH demonstrations.
Content changes	Refer to Appendix 2 for the standards and elements, with the associated points. The crosswalk below highlights the differences between PPC 2006 and PPC-PCMH.
Must Pass elements	<p>There are 10 must-pass elements. At a minimum (Level 1) practices must-pass 5 of these elements by performing at the 50 percent scoring level (earning half the points for the element).</p> <ul style="list-style-type: none"> • PPC 1: Access and Communication <ul style="list-style-type: none"> – Element A: Access and Communication Processes – Element B: Access and Communication Results • PPC 2: Patient Tracking and Registry Functions <ul style="list-style-type: none"> – Element D: Organizing Clinical Data – Element E: Identifying Important Conditions • PPC 3: Care Management <ul style="list-style-type: none"> – Element A: Guidelines for Important Conditions • PPC 4: Patient Self-Management Support <ul style="list-style-type: none"> – Element B: Self-Management Support • PPC 6: Test Tracking <ul style="list-style-type: none"> – Element A: Test Tracking and Follow Up • PPC 7: Referral Tracking <ul style="list-style-type: none"> – Element A: Referral Tracking • PPC 8: Performance Reporting and Improvement <ul style="list-style-type: none"> – Element A: Measures of Performance – Element C: Reporting to Physicians
New element	<p>The following element is new.</p> <ul style="list-style-type: none"> • PPC 8: Performance Reporting and Improvement <ul style="list-style-type: none"> – Element A: Patient Experience Data

Changed standard

The following standard replaces the previous PPC 9.

- PPC 9: Advanced Electronic Communications (*PPC 2006: Interoperability*)
 - Element A: Availability of Interactive Web site (*PPC 2006: Use of Prescribed Standardized Codes*)
 - Element B: Electronic Patient Identification (*PPC 2006: Electronically Receiving Data*)
 - Element C: Electronic Care Management Support (*PPC 2006: Electronically Transmitting Data*)

Scoring

- The number of overall points is the same, but in some cases the distribution has changed
 - The number of points increased for some elements
 - As indicated below, some standards and elements have been added and others have been deleted
- One scoring option at the element level changed
 - Increased from 20% to 25%
- The number of factors increased in some elements, but this did not change scoring for those elements

**Table 1: PPC 2006 to PPC-PCMH
Crosswalk**

SCORING IN PPC-PCMH:

1. The number of overall points is the same but in some cases the distribution has changed:
- The number of points increased for some elements.
 - As indicated below, some standards and elements have been added and others have been deleted.

2. One of the scoring options at the element level changed:
- Increased from 20%–25%.
3. The number of factors increased in some elements but this did not change the scoring for those elements.

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 1: Access and Communication	PPC 1A : Access and communication processes	4	4 Must-Pass	Added factor: Identifying health insurance resources for patients without insurance.			✓		
	PPC 1B: Access and communication results	4	5 Must-Pass	None					
PPC 2: Patient Tracking and Registry Functions	PPC 2A: Basic system for managing patient data	2	2	Added factors: Legal guardian, health insurance coverage and preferred method of communication			✓		
	PPC 2B: Electronic system for clinical data	3	3	Added factor: Head circumference for patients ≤2 years			✓	✓	
	PPC 2C: Use of electronic clinical data	3	3	None					
	PPC 2D: Organizing clinical data	6	6 Must-Pass	Added factor: Screening tool for developmental testing and growth charts.			✓	✓	
	PPC 2E: Identifying important conditions	4	4 Must-Pass	Added explanation for risk factors associated with practice's demographics.				✓	
	PPC 2F: Use of system for population management	2	3	Added factor: Patients who might benefit from care management. Added explanation for pediatrics.			✓	✓	

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 3: Care Management	PPC 3A: Guidelines for important conditions	3	3 Must-Pass	Added to element: ...evidence-based <i>diagnosis and treatment</i> guidelines...		✓			
	PPC 3B: Preventive service clinician reminders	4	4	Added examples for pediatric practices.				✓	
	PPC 3C: Practice organization	3	3	Expanded explanation of team of physicians and staff related to handling patient care responsibilities.			✓	✓	
	PPC 3D: Care management of important conditions	5 Must-Pass	5	Changed factors from setting to <i>writing</i> individualized care plans and treatment goals.			✓	✓	
	PPC 3E: Continuity of care	5	5	Added to element: ...patients transitioning to other care. Added factors: written transition plan and help identifying new PCP or specialist.		✓	✓	✓	
PPC 4: Patient Self-Management Support	PPC 4A: Documenting communication needs	2	2	None					
	PPC 4B: Self-management support	4	4 Must-Pass	Added factor: provides written care plan to patient/family. Added to explanation: written materials appropriate for patients. Added to examples: referrals to community resources.			✓	✓	✓
PPC 5: Electronic Prescribing	PPC 5A: Electronic prescription writing	3	3	None					
	Electronic prescribing interoperability	3	Deleted	Deleted					
	PPC 5C (B): Prescribing decision support—safety	3	3	None					
	PPC 5D (C): Prescribing decision support—efficiency	2	2	None					

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 6: Test Tracking	PPC 6A: Test tracking and follow-up	6	7 Must-Pass	Added factor: follow-up to get results on in-patient pediatric screening tests.			✓		
	PPC 6B: Electronic system for managing tests	6	6	None					
PPC 7: Referral Tracking	PPC 7A: Referral tracking	4	4 Must-Pass	Added to element: <i>Specialist or consultant</i> report. Added to explanation: clinical details to include in referral.		✓		✓	
	PPC 7B: Referral decision support	3	Deleted	Deleted					
PPC 8: Performance Reporting and Improvement	PPC 8A: Measures of performance	3 Must-Pass	3 Must-Pass	Added to factor: examples for pediatric practices.			✓		
	PPC 8B: Patient experience data		3	New	✓	✓	✓	✓	✓
	PPC 8C (8B): Reporting to physicians	3	3 Must-Pass	Added to explanation: staff meetings.				✓	
	PPC 8D (8C): Setting goals and taking action	3	3	Added family involvement.				✓	
	PPC 8E (8D): Reporting standardized measures	2	2	None					
	PPC 8F (8E): Electronic reporting—external entities	1	1	None					
PPC 9: Advanced Electronic Communications	PPC 9A: Availability of interactive Web site		1	New	✓	✓	✓	✓	✓
	PPC 9B: Electronic patient identification		2	New	✓	✓	✓	✓	✓
	PPC 9C: Electronic care management support		1	New	✓	✓	✓	✓	✓

PPC 2006 and PPC-PCMH Standards	PPC 2006 and PPC-PCMH Element Titles	PPC 2006 Points	PPC-PCMH Points	Description of Change	PPC-PCMH Changes, Additions or Deletions				
					Standards	Elements	Factors	Explanation	Examples
PPC 9: Interoperability	PPC 9A: Use of prescribed standardized codes	1	Deleted	Deleted					
	PPC 9B: Electronically receiving data	1	Deleted	Deleted					
	PPC 9D: Using data for referral reports	1	Deleted	Deleted					

PPC-PCMH Structure

Achievement levels In PPC-PCMH, there are three levels of achievement. Practices can gauge their ability to achieve these levels by assessing whether they perform the functions required in each element of each standard. Each element indicates the extent of information technology required for that element.

Level 1 25 points–49 points.

Must-pass elements = 5 of 10, with a performance level of at least 50%.

Level 2 50 points–74 points.

Must-pass elements = 10 of 10, with a performance level of at least 50%.

Level 3 75 points or more.

Must-pass elements = 10 of 10, with a performance level of at least 50%.

Must-pass elements These are elements that a practice must-pass at a 50% or greater score in order to achieve Recognition.

IT requirements

Basic *Requires an electronic practice management system.* Basic elements represent 60 percent of the elements in PPC v.2.

Intermediate *Requires further IT within the practice, such as an electronic health report (EHR) or e-prescribing capability.* Intermediate elements represent 33 percent of the elements in PPC 2006.

Advanced *Requires interoperable IT capabilities, such as the ability to electronically transmit and receive data between the practice and other entities.* Advanced elements represent 7 percent of the total elements.

PPC-PCMH Recognition Evaluation Process

NCQA uses the same evaluation process for all of its Physician Recognition Programs. The process to be Recognized is as follows.

1. The practice conducts a self-scoring readiness assessment using NCQA's Web-based Survey Tool, responding to questions and attaching supporting documentation to verify responses.
2. The practice uses the Survey Tool to submit its data for NCQA evaluation.
3. NCQA evaluates all data and documents submitted by the practice against the standards, and then scores the practice.
4. For at least 5 percent of practices, NCQA conducts an *additional, onsite audit*. During the audit, staff review source data, including medical records, to validate documentation and responses previously provided to NCQA.
5. NCQA provides final information to the practice.
6. NCQA reports information on the practice, its physicians and its level of performance to the NCQA Web site and to data users, including health plans and physician directory publishers.
7. NCQA does not report information on practices that do not pass at any level.

For additional information on NCQA's PPC-PCMH survey process, contact Customer Support at 888-275-7585 or go to NCQA's Web site at www.ncqa.org/ppc-pcmh.

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Policies and Procedures

Policies and Procedures

Participating in PPC-PCMH

The 2008 Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH) is NCQA's nationwide program that Recognizes physician practices functioning as medical homes. Practices are assessed using the PPC-PCMH Survey Tool available for applicants on NCQA's Interactive Survey System (ISS) beginning January 1, 2008.

For this program, a **physician practice** is one or more physicians at a single geographic location who practice together. The practice may include primary care physicians, specialty physicians or a combination.

Practicing together means that, for all the physicians in a practice:

- A single site is the location of practice for more than 50 percent of their clinical time
- Nonphysician staff follow the same procedures and protocols
- Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as appropriate
- The same systems—electronic (computer) and paper-based—and procedures support both clinical and administrative functions: scheduling time, treating patients, ordering services, prescribing, keeping medical records and follow-up.

Physician practices

Following are some examples of practices that qualify for PPC-PCMH evaluation.

- An incorporated group of three physicians in an office site who use the same systems and staff, as described above.
- An individual physician, whether sharing an office with other physicians or not, who maintains his or her own systems.
- A group of physicians at one location that is part of a larger medical group with several locations.
- A **multisite group** is multiple practice sites within a larger organization that use the same medical record systems and processes including an electronic system.

PPC-PCMH Requirements

The PPC-PCMH has nine standards in a single program, with one overall score. Each standard consists of several specific elements. The following nine standards evaluate the ability of a practice to function as a patient-centered medical home.

1. PPC 1: Access and Communication
2. PPC 2: Patient Tracking and Registry Functions
3. PPC 3: Care Management
4. PPC 4: Patient Self-Management Support
5. PPC 5: Electronic Prescribing
6. PPC 6: Test Tracking
7. PPC 7: Referral Tracking
8. PPC 8: Performance Reporting and Improvement
9. PPC 9: Advanced Electronic Communications

Using the PPC-PCMH Survey Tool

NCQA's PPC-PCMH standards and program information are available as an attachment to the Web-based Survey Tool (the Interactive Survey System – ISS) that incorporates the PPC-PCMH Standards and Guidelines. Practices enter responses in the Survey Tool and attach supporting documents to demonstrate the systems and processes of the practice that meet the PPC-PCMH program standards.

While the practice is using the Survey-Tool for its own evaluation, NCQA surveyors cannot access the Survey Tool, responses or any data entered or referenced documentation.

The following template shows how NCQA presents standards, scoring and related components of the PPC-PCMH program. The Survey Tool calculates results based on the information the practice enters.

Template for Standards and Elements**PPC-PCMH****100 point(s)****Standard PPC X: Title****XX point(s)**

NCQA standards are authoritative statements about acceptable performance or results. Each standard includes a statement of an attribute or expectation.

- Each standard has a number using the three-letter identifier and consecutive numbers (e.g., PPC 1, PPC 2), as well as a title.
- Each standard has a designated number of points, which is a sum of the points assigned to all the elements that the standard comprises. Both applicable standard points and applicable element points are shown.

Intent

The Intent is a brief statement explaining the purpose of the standard.

Element 1A: Title**XX point(s)**

There is at least one element for each standard. An element describes a specific component of performance that NCQA individually evaluates and scores.

- Each element has a designated number of points; element points sum to the standard points.
- Elements are alphabetically lettered within a standard (e.g., PPC 4A).
- The Tool calculates a practice's score on an element by multiplying its scoring level (a percentage, below) by its element points.

Factors

- Factors are subcomponents of the performance measured by an element and are used for scoring.
- Factors are numbered. Not all elements have factors.
- Where an element includes multiple numbered factors, the scoring (below) indicates the number of factors that the practice must meet to achieve each scoring level.

Scoring

	100%	75%	50%	25%	0%
	Performance level needed to score the total possible element points	Performance level needed to score 75% of the element points	Performance level needed to score 50% of the element points	Performance level needed to score 25% of the element points	Performance level that does not earn any points for the element

Each element has designated element points, or total possible points. The scoring indicates what the practice needs to do to achieve each of the five scoring levels for an element, and under what circumstances the element is not applicable to the practice.

Data source **Data sources** are types of documentation that practices need to submit to demonstrate performance related to specific elements. The list of data sources within each element is not prescriptive nor does it exclude other potential sources. The practice may have acceptable alternative methods that demonstrate performance.

Data sources *must* document that the practice has the required processes in place, not those it plans to implement in the future. There are four basic types of data sources practices can use to demonstrate performance.

1. **Documented process**—Written statements describing the practice's procedures. The statements may include protocols or other documents that describe actual processes or forms the practice uses in work flow such as referral forms, checklists and flow sheets. Forms should not be blank but instead should include blinded information that demonstrates how the practice uses it.
2. **Reports**—Aggregate data showing evidence of action, including manual and computerized reports the practice produces to manage its operations, such as a list of patients who are due for a visit or test.
3. **Records or files**—Actual patient files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element. There are two ways to measure this performance: a) a query of electronic files yielding a count or; b) the sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook, attached to the PCC-PCMH Web-based Survey Tool.
4. **Materials**—Prepared material the practice provides to patients or clinicians including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.

Scope of review NCQA scores most element once for the practice. However, with elements associated with clinically important conditions identified by the practice in the Survey Tool setup, NCQA scores the same element three times, once for each clinically important condition.

Explanation The explanation provides additional information to the practice, such as information on what NCQA is looking for, how the element relates to other elements, terms used and the evaluation process.

Examples Examples show one or more ways to meet the requirements of the element.

Exception Exceptions from the element are listed here. There are two types of exceptions: situations in which a factor or element is not applicable (NA); actions or types of evidence that might be considered to meet the standard, but do not.

Readiness Evaluation

The practice may conduct a readiness evaluation on the PPC-PCMH standards and elements prior to submitting the Survey Tool for NCQA's review. To be most accurate, the evaluation should be a thorough assessment of a practice's systems, including responses to questions, complete worksheets, as needed, and evaluation of supporting documentation. The Survey Tool estimates the score for each standard and element, which provides a preliminary score. While a practice conducts its readiness evaluation, NCQA surveyors do not have access to the Survey Tool, any data in it or any referenced documentation. The information is secure and confidential and for the practice's use only.

Applying for an NCQA PPC-PCMH Survey

For eligible physician practices, the following are instructions for steps the practices will take in applying for the PPC-PCMH survey.

Complete the application The PPC-PCMH application materials may be obtained by contacting NCQA's Customer Support staff at 888-275-7585 or by going to NCQA's Web site at <http://www.ncqa.org/Communications/Publications/index.htm>. The materials include the following components.

- **Agreement**—Includes:
 - Attestation, which indicates practice's support for the Joint Principles of the AAFP, AAP, ACP and AOA
 - NCQA Agreement
 - HIPAA Business Associate Agreement.

Print and sign two copies and mail to NCQA:

- **Practice Background Information Worksheet**—Provides the number and names of the physicians who practice at each practice location at least 51 percent of their time.
- **Application**—Provides relevant demographic information including the contact name, title of the person completing the application.
- **Multi-Site Group Survey Assessment Questionnaire**—To determine practice group eligibility for a linked survey; appropriate for practices with multiple sites utilizing the same medical record system and processes.

Execute the agreement Review the NCQA Agreement and sign two copies of the Attestation, the agreement, the data release and the Business Associate Agreement.

Submit documents Mail the following to NCQA.

- Application form
- Multi-Site Group Survey Assessment Questionnaire, if applicable
- Practice Background Information Worksheet
- Signed Attestation, agreement, data release and Business Associate Agreement (two copies)
- Application fee

Self-assess level of capability

Review the PPC-PCMH standards to determine if the practice performs the functions required by the elements under each standard. To help determine the capabilities of the practice, review the *Explanation* section of each element, which also indicates the level of health IT required.

Identify three clinically important conditions

Clinically important conditions are those on which the practice concentrates its care management; chronic or recurring conditions that the practice sees, such as otitis media, asthma, diabetes or congestive heart failure. The most frequently seen single-episode conditions also may be clinically important conditions for the practice, such as colds or urinary tract infections (UTI).

Practices may choose their own method of determining the most important conditions or most frequently seen conditions. Conditions may be based on:

- The most patients
- The most visits
- The greatest costs
- The best likelihood of being amenable to care management.

Other evidence, such as performance measures required for reporting to external entities.

Go to the **Survey Tool Set-up** tab at the top of the screen and identify the three clinically important conditions for your practice. *Select only three conditions*. This will allow the Survey Tool to score the practice three times for the specific elements that require it.

Completing the Survey Tool

Step 1 *Respond to questions.* Indicate the response for each element that corresponds to the practice's capabilities and for which the practice can provide documentation that supports the response.

Step 2 *Complete the worksheets (if applicable).* Two optional worksheets are attached to the Survey Tool, *The Quality Measurement and Improvement Worksheet* and *The Record Review Workbook*. You may need to complete one or both of them.

If you plan to use the worksheets, download them, enter the requested information and then reattach them following the directions in the Survey Tool.

- *The Quality Measurement and Improvement Worksheet* (in Microsoft Word)—This worksheet relates to PPC 8C and D and is a method of documenting quality measurement and improvement efforts.
- *The Record Review Workbook* (in Microsoft Excel)—Elements PPC 2C, 2D, 3D, 4B ask for percentages of patients. This worksheet is a tool for the practice to use to review records and estimate the percentages of patients included in the required functions. The alternative to the worksheet is for practices to query their electronic system as described in the *Explanations*.

Step 3 *Attach documentation.* All elements require practices to attach documents to demonstrate performance. Each element indicates the recommended data source, as described above.

NCQA requests that you attach *no more than three documents per element*.

The Survey Tool gives instructions for attaching documentation. Once you attach the documents, the Tool lists them in a document library and references the appropriate element to which the document is attached.

Please note the following important information related to attached documents.

- Protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations, *must be removed or blocked out* from documents submitted, *specifically patient identifiers* unless the Survey Tool indicated otherwise. To the extent that the Survey Tool requests PHI NCQA's use and access to this information is governed by the HIPAA Business Associate Agreement.
- You may provide Web links to data or Web sites. If you have documentation that is impossible to attach electronically or for which there is no electronic link, contact NCQA.
- Identify and attach documentation as you respond to each question in the Survey Tool, rather than saving it until you have answered all questions.
- For many elements, the best documentation is screen shots from a computer application that the practice uses. Convert screen shots to Word or portable document format (PDF).
- You may use the same documents for more than one element, when applicable.

Note: *The ISS cannot accept documents in html format.*

Until you formally submit the Survey Tool to NCQA, you can revise your responses to questions, enter comments and update or change the attached documents.

Step 4 *Upload documents.* This is a separate step that enables you to upload your attached documents to NCQA's server for NCQA review. The Survey Tool has instructions for uploading documents.

Step 5 Submit application, application fee and agreement.

Note: *You cannot complete your submission until NCQA receives your application and establishes an electronic link between your Survey Tool and the NCQA server.*

Step 6 *Submit the Survey Tool* with the attached documentation. The date on which you submit the Survey Tool to NCQA is the date NCQA officially begins its survey of your data. When you submit the Survey Tool to NCQA, you will still be able to view *your copy* of the completed Survey Tool and all of the attached documents and you may modify it for your own purposes. However, the official copy sent to NCQA, and all the data in it, are considered final for purposes of NCQA conducting its evaluation of your PPC-PCMH Survey Tool. You will not have access to NCQA's copy of your completed Survey Tool and you cannot change data after submission or view NCQA's review of the results until NCQA has finished.

NCQA sends an e-mail confirming its receipt of the Survey Tool and the start of the evaluation period. NCQA staff review and assess the completeness of application data and Survey Tool materials and notify you if additional information is required. If NCQA requests additional information, your practice must submit the documentation to NCQA within 30 days of the request. NCQA attaches the additional documentation to the Survey Tool originally submitted.

- Offsite survey** Trained NCQA internal and external surveyors access the Survey Tool submitted to NCQA. The surveyors evaluate the responses and documentation against program standards and determine scores for each relevant element and standard. NCQA makes its final scoring decision within 30 days of receiving a completed Survey Tool.
- If the practice is one of a group of practices participating in a Multi-Site Group Survey, NCQA reviews the standards in the Multi-Site Group Survey first and applies the results to all practices in the group, then reviews the Survey Tools with site-specific data.
- Audit** NCQA reserves the right to audit any practice that applies for a PPC-PCMH Survey. NCQA conducts audits of at least 5 percent of the applicants, chosen randomly or on the basis of specific criteria.
- NCQA conducts the audit prior to making a final decision about whether the practice has met PPC-PCMH standards, and notifies the practice, schedules the audit and provides instructions on audit requirements. Determining the final result for audited practices takes longer than the 30-day time period described above.
- Failure to pass an audit results in no further consideration for PPC-PCMH Recognition for one year after the date the practice submitted the completed Survey Tool to NCQA.

Survey Results

NCQA makes a decision on whether a practice has achieved Recognition on the basis of its overall performance against the standards. Decisions are based on a numeric score. PPC-PCMH has three Recognized levels. To be Recognized, a practice must achieve a score in one of the following ranges:

Number of Points	Number of Points	Must-Pass Elements at 50% Scoring Level
Level 1	25–49 points	5 of 10
Level 2	50–74 points	10 of 10
Level 3	75–100 points	10 of 10

If there is a difference in Level achieved between the number of points and Must-pass, the practice is awarded the lesser. For example, a practice that has 65 points but passes only seven must-pass elements achieves Level 1. Practices with a numeric score of 0–24 points or less than 5 must-pass elements do not achieve Recognition. NCQA does not publish the name of any practice that does not achieve Recognition.

To pass, each must-pass element must reach a 50% scoring level, for example two out of four possible points.

Scoring is built into the Survey Tool and is described below.

Scoring Guidelines

Elements	<p>An element is a specific component of a standard that NCQA individually evaluates and scores.</p> <p>The Survey Tool multiplies the element's scoring level by its weight in points to determine the element score. As determined by NCQA, some elements may be scored NA if they do not apply to the practice. In that case, the Survey Tool redistributes the element's points proportionately across the other elements within the standard.</p> <p>NCQA scores some elements multiple times, once for each clinically important condition. In those cases, reviewers score the element for each clinical condition. The Survey Tool calculates an average scoring level across the multiple scores to arrive at a score for the element. The resulting average may be any percentage between 0 and 100% (e.g., the average of 75%, 75% and 100% is 83.3%). The score is then multiplied by the element's points.</p> <p>Example <i>PPC 1, Element A: Access and Communication Processes</i>, is worth 4 points. If the evaluation of the practice's performance in Element A is 100%, the practice receives 4 points, but if the practice's performance is 50%, it receives 2 points.</p>
Calculating the standard score	<p>The Survey Tool adds the scores received for all elements in a standard to determine the score received for the standard.</p> <p>Example PPC 1 is worth a total of 8 points. An evaluation of the practice's performance in PPC 1 shows it received 4 points for Element A and 2 points for Element B. The practice receives 6 of the 8 possible points for the standard.</p>
Calculating the overall score	<p>The Survey Tool adds the scores received for all standards to determine the final score.</p> <p>Example Table 1 below provides an example of a practice's performance.</p>
Preliminary results	<p>The preliminary results of NCQA's scoring decisions are shown in the Final Results section of the Survey Tool. This section consists of tabular findings on:</p> <ul style="list-style-type: none">• Preliminary scores for each element and standard• Number of must-pass elements• Total score. <p>If the score is not sufficient for any level of Recognition, NCQA notifies and discusses the results with the practice and will give the practice access to the Survey Tool for review and comment. The practice has 14 calendar days to submit comments on areas in which it believes NCQA misinterpreted the information and should have scored the practice higher. The practice may submit additional documentation as evidence, but only if the documentation was available before the practice originally submitted the Tool.</p> <p>NCQA reviews the comments and incorporates changes into the Survey Tool that NCQA in its sole discretion deems relevant to meeting the elements and standards.</p>

Table 2: Scoring Example

Standard	Points Scored/ Total Points	Standard	Points Scored/ Total Points	Standard	Points Scored/ Total Points	Standard	Points Scored/ Total Points
PPC 1		PPC 3		PPC 5		PPC 8	
PPC 1A**	2/4—P	PPC 3A**	3/3—P	PPC 5A	0/3	PPC 8A**	3/3—P
PPC 1B**	2/5—NP	PPC 3B	0/4	PPC 5B	0/3	PPC 8B	0/3
		PPC 3C	3/3	PPC 5C	0/2	PPC 8C**	2/3—P
PPC 2		PPC 3D**	5/5—P			PPC 8D	0/3
PPC 2A	1/2	PPC 3E	5/5	PPC 6		PPC 8E	0/2
PPC 2B	0/3			PPC 6A**	3/7—NP	PPC 8F	0/1
PPC 2C	0/3	PPC 4		PPC 6B	0/6		
PPC 2D**	2/6—NP	PPC 4A	2/2			PPC 9	
PPC 2E**	2/4—P	PPC 4B**	0/4—NP	PPC 7		PPC 9A	0/1
PPC 2F	0/3			PPC 7A**	0/4—NP	PPC 9B	0/2
						PPC 9C	0/1

**Must-pass elements (≥50%) P = Passed NP = Not Passed

FINAL STATUS = Recognized, Level 1

Total points = 35/100

Total Must-Pass = 5/10

Final Decision and Status

NCQA utilizes members of a committee of external experts—the PPC-PCMH Review Oversight Committee (ROC)—to review findings and make final scoring decisions, and then incorporates the scores into the final version of the Survey Tool, which generates final results for the practice. ROC members are physicians who have expertise in practice systems and who, as determined by NCQA, have no conflict of interest.

The Results section of the Survey Tool shows the practice's status.

Not Recognized	Indicates that the total score was not high enough to pass any of the levels needed to achieve Recognized status. NCQA does not report the Not Recognized status on its Web site or to any other organization. The practice may reapply to achieve Recognition one year after the submission date of its original completed application.
Must-pass elements	Of the 30 elements in PPC-PCMH, 10 are must-pass, that is, elements that a practice must-pass at 50% or greater score to achieve Recognition. <ol style="list-style-type: none"> PPC 1, Element A: Access and Communication Processes PPC 1, Element B: Access and Communication Results PPC 2, Element D: Organizing Clinical Data PPC 2, Element E: Identifying Important Conditions PPC 3, Element A: Guidelines for Important Conditions PPC 4, Element B: Self-Management Support PPC 6, Element A: Test Tracking and Follow-Up

8. PPC 7, Element A: Referral Tracking
9. PPC 8, Element A: Measures of Performance
10. PPC 8, Element C: Reporting to Physicians

The table on p. 23 in the Survey Results section specifies the number of elements required for Recognition at each level. To pass a must-pass element, the practice must receive a score of at least 50% of the total points designated for that element. Practices that achieve less than 5 must-pass elements do not achieve Recognition.

Certificates	NCQA issues an official Recognition certificate acknowledging that the practice met the standards.
Duration of status	Recognition status lasts three years. A practice that wants to achieve a higher level of Recognition status may apply for an Add-On Survey (see below).

Reporting Results

...To the practice	NCQA provides the practice with a final version of the Survey Tool that includes the final status and level, as well as numerical scores on all elements and all standards. If the reviewer did not concur with the practice's self-assessment, the practice may review the comments.
...To the public	Recognized practices and their physicians are added to the list of practices on NCQA's Web site (www.ncqa.org/programs/ppc-pcmh). NCQA does not report practices that are Not Recognized.
...To organizations	NCQA sends a list of Recognized practices and physicians and the levels they achieve to organizations that reward physicians for achieving Recognition.

Add-On Survey

To move from Level 1 to Level 2 or Level 3, or from Level 2 to Level 3, the practice may apply for an add-on survey up to two times within the 3-year period of the initial Recognition. For each Add-On Survey, the practice uses the Survey Tool to submit data for elements where it earned a score of 75% or below. NCQA evaluates data for the elements submitted and produces a new total score for the standards.

NCQA evaluates the elements submitted according to the process described in this document and sends the results to the practice. If the practice achieves Recognition at a new level, NCQA reports the new level.

Reconsideration

A practice may request Reconsideration of any NCQA status decision of Not Recognized. NCQA must receive a request for Reconsideration within 30 days after the practice is notified that it has received a status of Not Recognized. NCQA refers the request to the PPC Reconsideration Committee, a 3-person committee consisting of experts external to NCQA.

The Reconsideration Committee reviews paper documentation from the practice as well as all information in the Web-based Survey Tool. The practice must describe the reason for requesting the Reconsideration and list standards or elements for which it requests Reconsideration. It may not submit additional documentation at this time, but may state how it believes NCQA misinterpreted the original documentation. The Reconsideration Committee's decision is final and is sent to the practice in writing. There is no further right of appeal.

Administrative Policies

Organization obligations

By submitting the PCC-PCMH application to NCQA, the applicant agrees to the following.

- To release the information to NCQA that NCQA deems pertinent.
- To hold NCQA, its directors, officers, employees, agents and representatives harmless from any claims related to 1.) third party claims for malpractice or injury by physician practice; 2.) the physician practice's failure to achieve desired results under the PPC-PCMH survey; and 3.) payment and network decisions made by third parties based on physician practice's status as PPC-PCMH Recognized.
- To abide by the terms of the Contract, these procedures and instructions and all other published NCQA policies, procedures and rules.
- To notify NCQA of the request for corrective action, imposition of sanctions or changes in licensure or qualification status. Such notification must be sent to NCQA no later than 30 days after the practice receives notice of such action.
- To accept all NCQA determinations regarding the physician practice's PPC-PCMH status.
- To agree that NCQA makes no warranties or representations to others and that the provision of health care advice is solely the responsibility of the physician practice or a third party.
- To agree that a PPC-PCMH status by NCQA does not constitute a warranty or any other representation by NCQA to any third parties (including, but not limited to, employers, consumers or payers) regarding the quality or nature of the health-related services provided or arranged for by the physician practice.
- To agree that any information created as a part of the PPC-PCMH survey of the physician practice by NCQA shall be kept confidential, except as indicated in the section *Reporting Results*, unless otherwise agreed to by NCQA.
- To agree that the PPC-PCMH program is not a replacement for a physician practice's evaluation, assessment and monitoring of its own services and programs.
- To not misrepresent its PPC-PCMH status (including, but not limited to, the scope and meaning of such status as defined herein) or suggest that it has received a PPC-PCMH status by NCQA when such representation is not accurate.
- To notify NCQA of any material changes in the structure or operation of the physician practice, or merger, acquisition or consolidation of the physician practice in accordance with these Policies.

If NCQA identifies a deficiency in a physician practice's operations that poses a threat to patient or public health or safety, it may notify the applicable regulatory agencies, following notice to the physician or the chief executive officer or medical director of the group.

Discretionary Survey

At its discretion, NCQA may review a practice while a Recognized status is in effect. The purpose of such a review is to validate the appropriateness of an existing Recognition decision. The decision to initiate a Discretionary Survey is made by the vice president of NCQA, who oversees PPC-PCMH, and the NCQA general counsel.

Structure Discretionary Surveys are specifically targeted to address issues indicating that a practice may not continue to meet the NCQA standards that were in effect at the time of Recognition. The scope and content of the review are determined by NCQA. Discretionary Surveys may consist of an offsite document review, an onsite review or a teleconference.

If a Discretionary Survey requires an onsite review, NCQA conducts the review within 60 calendar days of the notification by NCQA of the intent to conduct a Discretionary Survey. The costs of a Discretionary Survey are borne by the practice and correspond to the complexity and scope of the review and NCQA's pricing policies in effect at the time.

Change in Recognition status When NCQA notifies the practice of its intent to conduct a Discretionary Survey, it removes the practice's name from the NCQA Web site.

NCQA conducts the review against standards that were in effect at the time the practice gained Recognition status from NCQA. Following completion of the Discretionary Survey and the ROC's decision regarding the review, and depending on the decision, NCQA will either restore the practice's listing on the NCQA Web site or will not. If appropriate, NCQA will inform external organizations that use the information of the outcome of the Discretionary Survey. The Discretionary Survey does not extend the length of the existing status. The practice has the right to a Reconsideration of the determination should its status change as a result of the Discretionary Survey.

Revoking Decisions

NCQA may revoke a PPC-PCMH decision if any of the following happen.

- The practice submits false data or does not collect data according to the procedures outlined in this manual.
- The practice misrepresents the credentials of any of its physicians.
- The practice misrepresents its PPC-PCMH status.
- Any of the practice's physicians experience a suspension or revocation of medical licensure.
- The practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the practice's operations.
- NCQA identifies a significant threat to patient safety or care.

When communicating with patients, third-party payers, managed care organizations (MCO) and others, physician practices who receive PPC-PCMH Recognized may represent themselves as having been Recognized by NCQA for meeting PPC-PCMH standards, but may not characterize themselves as "NCQA-approved" or "NCQA-endorsed." The use of this mischaracterization or other similarly inappropriate statements is grounds for revocation of status.

Mergers, Acquisitions and Consolidations

Recognized practices must report to NCQA any merger, acquisition or consolidation activity in which they are involved. Based on the circumstances, NCQA makes a determination about the need for additional information and the need for a further evaluation.

Revisions to Policies and Procedures

At its sole discretion, NCQA may amend any PPC-PCMH policy and procedure. Notice of and information about modifications or amendments are sent to physician practices 30 calendar days before the effective date of the modification or amendment.

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**Physician Practice Connections—
Patient-Centered Medical Home
(PPC-PCMH) Standards**

PPC 1: Access and Communication**9.00 points**

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Intent

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

Element A: Access and Communication Processes**4.00 points**

The practice establishes in writing standards for the following processes to support patient access:	Yes	No	NA
1. Scheduling each patient with a personal clinician for continuity of care	<input type="checkbox"/>	<input type="checkbox"/>	
2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip	<input type="checkbox"/>	<input type="checkbox"/>	
3. Determining through triage how soon a patient needs to be seen	<input type="checkbox"/>	<input type="checkbox"/>	
4. Maintaining the capacity to schedule patients the same day they call	<input type="checkbox"/>	<input type="checkbox"/>	
5. Scheduling same day appointments based on practice's triage of patients' conditions	<input type="checkbox"/>	<input type="checkbox"/>	
6. Scheduling same day appointments based on patient's/family's requests	<input type="checkbox"/>	<input type="checkbox"/>	
7. Providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time	<input type="checkbox"/>	<input type="checkbox"/>	
8. Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week	<input type="checkbox"/>	<input type="checkbox"/>	
9. Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time	<input type="checkbox"/>	<input type="checkbox"/>	
10. Providing an interactive practice Web site	<input type="checkbox"/>	<input type="checkbox"/>	
11. Making language services available for patients with limited English proficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Identifying health insurance resources for patients/families without insurance.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring

100%	75%	50%	25%	0%
Practice has written process for 9-12 items	Practice has written process for 7-8 items	Practice has written process for 4-6 items	Practice has written process for 2-3 items	Practice has written process for 0-1 items

Data source Documented process, Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Condition-specific: No
Details: The practice should have standards for staff to respond to requests during office hours as well as to urgent concerns after hours. The following points apply to particular items.

- *Item 1*—If the practice does not assign patients to a personal physician, the practice may use their written policy for scheduling patients with a requested physician.
- *Item 2*—The goal is to minimize trips for the patient and as much as possible provide one-stop shopping.
- *Item 7*—Staff return patient calls within a time frame specified by the practice's policies.
- *Item 8*—A phone message that only directs patients to the emergency room after hours does not meet the standard.
- *Items 9 and 10*—Some practices use secure e-mail or an interactive Web site, either attached to the practice or from an external organization, for making appointments, communicating test results, renewing prescriptions or other nonurgent needs.
- *Item 11*—Where applicable, practices should utilize interpretation services. The practice does not need a written policy or data to demonstrate that it makes language services available. If a practice has multilingual staff, it does not need a written policy or data to demonstrate that it makes language services available. The practice may write a note in the Support Test/Notes box in the Survey Tool stating the percent of patients needing language services and the languages the staff speak.

Examples **Data source:** Written procedures for staff for appointments, triage and patient communication; log or schedule to demonstrate capacity (Item 3).

Element B: Access and Communication Results	5.00 points		
The practice's data shows that it meets access and communication standards in 1A:	Yes	No	NA
1. Visits with assigned personal clinician for each patient	<input type="checkbox"/>	<input type="checkbox"/>	
2. Appointments scheduled to meet the standards in Items 2-6 in 1A	<input type="checkbox"/>	<input type="checkbox"/>	
3. Response times to meet standards for timely response to telephone requests	<input type="checkbox"/>	<input type="checkbox"/>	
4. Response times to meet its standards for timely response to e-mail and interactive Web requests	<input type="checkbox"/>	<input type="checkbox"/>	
5. Language services for patients with limited English proficiency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice's data meets 5 items	Practice's data meets 4 items	Practice's data meets 3 items	Practice's data meets 2 items	Practice's data meets 0-1 items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic—Intermediate

Condition-specific: No

Details: The tracking reports should show that the practice meets its own standards for access through appointments, telephone calls and e-mail or interactive Web site where applicable.

The practice can do spot checks for these items, such as monitoring appointment wait times and telephone response times for a week to determine how well it meets standards.

Practices may provide patient experience survey results, if the questions are specific to the access and communication factors.

For Item 4, the practice may exclude patients who do not have e-mail.

The practice may respond "not applicable" (NA) to Item 5 if its patient population does not require language services.

Examples **Data source:** Tracking reports, either paper or screen shots, showing records for a period of appointments with personal clinicians, average wait for appointments, average time for returning telephone calls and e-mails.

PPC 2: Patient Tracking and Registry Functions 21.00 points

The practice systematically manages patient information and uses the information for population management to support patient care.

Intent

The practice has readily accessible, clinically useful information on patients that enables it to treat patients comprehensively and systematically.

Element A: Basic System for Managing Patient Data 2.00 points

The practice uses an electronic data system for patients that includes the following searchable patient information:

	Yes	No	NA
1. Name	<input type="checkbox"/>	<input type="checkbox"/>	
2. Date of birth	<input type="checkbox"/>	<input type="checkbox"/>	
3. Gender	<input type="checkbox"/>	<input type="checkbox"/>	
4. Marital status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Language preference	<input type="checkbox"/>	<input type="checkbox"/>	
6. Voluntarily self-identified race/ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	
7. Address	<input type="checkbox"/>	<input type="checkbox"/>	
8. Telephone (primary contact number)	<input type="checkbox"/>	<input type="checkbox"/>	
9. E-mail address (or "none" for patients)	<input type="checkbox"/>	<input type="checkbox"/>	
10. Internal ID	<input type="checkbox"/>	<input type="checkbox"/>	
11. External ID	<input type="checkbox"/>	<input type="checkbox"/>	
12. Emergency contact information	<input type="checkbox"/>	<input type="checkbox"/>	
13. Current and past diagnoses	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dates of previous clinical visits	<input type="checkbox"/>	<input type="checkbox"/>	
15. Billing codes for services	<input type="checkbox"/>	<input type="checkbox"/>	
16. Legal guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Health insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>	
18. Patient/family preferred method of communication.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
	12-18 items were entered for 75-100% of patients	8-11 items were entered for 75-100% of patients	6-7 items were entered for 75-100% of patients	4-5 items were entered for 75-100% of patients	0-3 items were entered for 75-100% of patients

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Condition-specific: No
Details: A practice management system or registry may enable the practice to meet this element; an EHR or more sophisticated system should include this basic data also.
 This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice should query its electronic registry, practice management system or other electronic system(s) to obtain data as follows:

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

Item 9—The item evaluates the capacity of the electronic system of the practice to collect e-mail addresses from its patients; it does not depend on whether or not a given patient has an e-mail address.
 The report should show how many items are entered for 75 percent to 100 percent of patients.
Item 10—The Internal ID is the primary identifier established and used by the practice to identify patients.
Item 11—The external ID is an identification number by which a patient is identified in a data base that is external to the practice (i.e., an identification number from a hospital, facility or provider that is outside of the practice).

Examples **Data source:** Reports from electronic systems.

Element B: Electronic System for Clinical Data		3.00 points			
The practice’s clinical data system or systems to manage care of patients include the following clinical patient information in searchable data fields:		Yes	No	NA	
1.	Status of age-appropriate preventive services (immunizations, screenings, counseling)	<input type="checkbox"/>	<input type="checkbox"/>		
2.	Allergies and adverse reactions	<input type="checkbox"/>	<input type="checkbox"/>		
3.	Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
4.	Height	<input type="checkbox"/>	<input type="checkbox"/>		
5.	Weight	<input type="checkbox"/>	<input type="checkbox"/>		
6.	Head circumference for patients 2 years or younger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Body mass index (BMI) calculated	<input type="checkbox"/>	<input type="checkbox"/>		
8.	Laboratory test results	<input type="checkbox"/>	<input type="checkbox"/>		
9.	Presence of imaging results	<input type="checkbox"/>	<input type="checkbox"/>		
10.	Presence of pathology reports	<input type="checkbox"/>	<input type="checkbox"/>		
11.	Presence of advance directives.	<input type="checkbox"/>	<input type="checkbox"/>		
Scoring	100%	75%	50%	25%	0%
	System has 9-11 data fields	System has 7-8 data fields	System has 5-6 data fields	System has 3-4 data fields	System has 0-2 data fields

Data source	Reports
Scope of review	ONCE—NCQA scores this element once for the organization.
Explanation	<p>IT required: Intermediate</p> <p>Source of content: IOM EHR Letter Report</p> <p>Condition-specific: No</p> <p>Details: For this element, the system may be a registry, electronic health record or combination of systems. The practice uses its systems for internally generated clinical data. All items should be kept in coded form; for Items 8–11, data may indicate the presence of a written report not in the system.</p> <p>For children under age 18, Item 7 is BMI percentile. For children under age 18, practice can enter "NA" in the clinical data system. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States.</p> <p>Head circumference in children under 2 years of age is a vital growth parameter that provides a sensitive guide to the child's health, development, nutritional status and response to treatment.</p> <p>A practice may have paper reports documenting the following items:</p> <ul style="list-style-type: none"> • Presence of imaging results • Presence of pathology results • Presence or absence of advance directives
Examples	<p>Data source: Screen shots or reports showing fields in patient records. Where applicable, these fields may show that the patient has no allergies or lab or imaging tests.</p>

Element C: Use of Electronic Clinical Data	3.00 points
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The practice uses the fields listed in 2B consistently in patient records.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75-100% of patients seen in the past 3 months have at least 7 fields completed	50-74% of patients seen in the past 3 months have at least 7 fields completed	25-49% of patients seen in the past 3 months have at least 7 fields completed	10-24% of patients seen in the past 3 months have at least 7 fields completed	Less than 10% of patients seen in the past 3 months have at least 7 fields completed

Data source Records or files

Scope of review	ONCE—NCQA scores this element once for the organization.
Explanation	<p>IT required: Intermediate</p> <p>Source of content: IOM</p> <p>Condition-specific: No</p> <p>Details: This element calls for calculation of a percentage that generally requires a numerator and a denominator. The practice should query its electronic registry, practice management system or other electronic systems to obtain data as follows:</p> <ul style="list-style-type: none">• Denominator = Total number of patients seen at least once by the practice in the last three months• Numerator = Number of patients for whom at least seven fields are entered. <p>The report must show the percent of patients seen in the last three months for whom the practice has entered at least seven of the items in 2B.</p> <p>If the system has capability to store items in data fields but the practice does not use it, the practice may receive an override score of 25% credit.</p> <p>This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:</p> <p>Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.</p> <ul style="list-style-type: none">• Denominator = Total number of patients seen at least once by the practice in the last three months• Numerator = Number of patients for whom at least seven fields are entered. <p>Method 2—Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see element 2E):</p> <ul style="list-style-type: none">• Denominator = The sample of patient medical records using NCQA's sampling method in the Record Review Worksheet• Numerator = The patients from the medical record review for whom at least seven fields are entered.• To receive credit the practice must show the percentage of patients seen in the past three months for whom the practice has documented information in the charting tools.
Examples	Data source: Reports from electronic system.

Element D: Organizing Clinical Data 6.00 points

The practice uses the following electronic or paper-based charting tools to organize and document clinical information in the medical record:

1. Problem lists
2. Lists of over-the-counter medications, supplements and alternative therapies
3. Lists of prescribed medications including both chronic and short-term
4. Structured template for age-appropriate risk factors (at least 3)
5. Structured templates for narrative progress notes
6. Age appropriate standardized screening tool for developmental testing
7. Growth charts plotting height, weight, head circumference and BMI, if less than 18 years.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75-100% of records of patients seen in the past 3 months include at least 3 tools with information documented	50-74% of records of patients seen in the past 3 months include at least 3 tools with information documented	25-49% of records of patients seen in the past 3 months include at least 3 tools with information documented	10-24% records of patients seen in the past 3 months include at least 3 tools with information documented	Less than 10% of patient records include at least 3 tools

Data source Records or files

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Source of content: IOM EHR Letter Report
Condition-specific: No
Details: Use of charting tools encourages clinicians to be consistent when they document patient information and findings. This element measures the degree of use of a systematic process that does not rely on the clinicians' memory to document certain clinical information—the paper or electronic tool prompts them to do so. Further, the charting tools require a response to each item, prompting the clinician to note either the presence of problems, prescribed medications and risk factors or that the patient has none.
Item 4, age-appropriate risk factor assessments, should come from evidence-based guidelines. Age-appropriate risk factors may include, but are not limited to the following examples:

- Use of tobacco for age 12 and over
- Cognitive assessment for new patients over 75
- Use of alcohol for age 15 and over
- Risk of falls for the elderly
- Secondhand smoke

- Use of seat belts
- Use of bike helmets
- Mental health concerns
- Obesity
- At-risk sexual behavior
- Violence
- Family history of cancer or diabetes.

Item 4 requires the practice to record assessment findings for three age-appropriate risk factors (i.e., smoking—no history, alcohol—1 beer per day, weight—170 lbs., height—5'1"). The practice should show it documents assessment of age-appropriate risk factors in its electronic system or paper flow sheet, questionnaire or checklist at every appropriate visit.

Item 5 requires the practice to use a standard format for progress notes, paper or electronic.

Item 6—Early intervention services for children from birth–3 years of age and early childhood education services for children 3–5 years of age are widely available for children with developmental delays or disabilities in the United States. Early identification of children with developmental delays is vital in the primary care setting. Examples of parent report instruments: Parents Evaluation of Developmental Status, Ages and Stages Questionnaires, Child Development Inventories. Examples of instruments that involve direct examination of the child's skills: Denver II screening test, Bayley Infant Neurodevelopmental Screener, Battelle Developmental Inventory, Early Language Milestone Scale, Brigance Screens.

Item 7—Growth measurements encompass the measurement of height, weight, head circumference and Body Mass Index. These measurements are plotted against the age of the child in standardized universal growth charts (CDC growth charts). CDC growth charts assess physical growth in children and adolescents. Using these charts, health care providers can compare growth in infants, children and adolescents with a nationally representative reference based on children of all ages and racial or ethnic groups. Comparing body measurements with the appropriate age- and gender-specific growth chart enables health care providers to monitor growth and identify potential health- or nutrition-related problems.

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

Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

- Denominator = Total number of patients seen at least once by the practice in the last three months
- Numerator = Number of patients for whom three tools have information entered.

Method 2—Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see Element 2E).

- Denominator = The sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = The patients from the medical record review for whom three tools are completed.

To receive credit the practice must show the percentage of patients seen in the past three months for whom the practice has documented information in the charting tools.

Examples

Data source: Medical record review.

Charting tools in the medical record may be paper-based or electronic templates or paper-based flow sheets. An EHR or a paper-based flow sheet may include several of the tools listed.

Element E: Identifying Important Conditions 4.00 points

The practice uses an electronic or paper-based system to identify the following diagnoses and conditions:	Yes	No
1. Practice's most frequently seen diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
2. Most important risk factors in the practice's patient population	<input type="checkbox"/>	<input type="checkbox"/>
3. Three conditions that are clinically important in the practice's patient population.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice identifies 3 items	Practice identifies 2 items	Practice identifies 1 item	No scoring option	Practice identifies 0 items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Condition-specific: No
Details: This element requires the practice to use data for population management, producing reports on most frequently seen conditions and risk factors, and determining three conditions on which it concentrates care management.
 The most **frequently seen diagnoses** are those that the practice sees most often and may include single episode conditions, such as colds or urinary tract infections, or chronic conditions. The practice can use any of the following criteria to identify the most frequently seen diagnoses, the most important risk factors and the three important conditions:

- Number of patients with the conditions, problems or risk factors
- Number of visits for the conditions or problems
- Total fees billed or other measures of cost associated with the conditions or problems, or risk factors.

To identify the most **important risk factors** in the practice's population, the practice uses community-based demographic characteristics of its patients and identifies the risks generally associated with these demographic characteristics (e.g. poverty).

Alternatively the practice may analyze the presence or absence of those risk factors in its own patient population.

To determine the **clinically important conditions**, the practice analyzes its entire population. In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions. The clinically important conditions are chronic or recurring conditions that the practice sees such as otitis media, asthma, diabetes or congestive heart failure. In some cases, the most frequently seen conditions may be the same as the clinically important conditions. In addition, the practice can also use the following criteria to identify the three important conditions:

- Ability to treat or change the conditions or problems (how amenable the conditions are to care management; whether clinical guidelines are available)
- Other evidence such as conditions for which the practice is measuring performance or receiving rewards for performance; conditions that the practice has selected or targeted to improve performance.

Examples **Data source:** Reports

Element F: Use of System for Population Management **3.00 points**

The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, as follows:	Yes	No
1. Patients needing pre-visit planning (obtaining tests prior to visit, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients needing clinician review or action	<input type="checkbox"/>	<input type="checkbox"/>
3. Patients on a particular medication	<input type="checkbox"/>	<input type="checkbox"/>
4. Patients needing reminders for preventive care	<input type="checkbox"/>	<input type="checkbox"/>
5. Patients needing reminders for specific tests	<input type="checkbox"/>	<input type="checkbox"/>
6. Patients needing reminders for follow-up visits such as for a chronic condition	<input type="checkbox"/>	<input type="checkbox"/>
7. Patients who might benefit from care management support.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses information to take action on 5-7 items	Practice uses information to take action on 3-4 items	Practice uses information to take action on 1-2 items	No scoring option	Practice does not use information to take action

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Intermediate
Condition-specific: No

Details: The electronic system provides practice-wide reports on any of the following fields: demographic information, contact information such as zip codes, imaging tests, laboratory tests, prescription medications, over-the-counter medications, diagnosis or treatment codes, status of preventive health services and risk factors. The practice

uses information from the reports to manage specific populations of patients (e.g., patients with diabetes).

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

Some examples of the population management function are these or similar items.

- Identify all patients who are taking a medication for which the practice received a warning.
- Identify all patients with ischemic vascular disease not taking appropriate medication.
- Identify all children with developmental delay
- Identify all children and adolescents with asthma
- Identify all women over 50 who are due for a mammogram
- Identify all adult patients with elevated LDL for whom appropriate medication has not been prescribed
- Identify all diabetic patients whose HbA1c >9
- Identify all patients with blood pressure >140/90

The practice's system needs to link the decision rules to the relevant patient-specific data, such as demographics, age, ICD Diagnosis codes, CPT¹ Procedure codes, test results, medication and clinical data (e.g., blood pressure, weight or BMI, smoking status).

If the system has the capability to generate lists but has not used it, the practice may receive an override score of 25%.

Examples

Data source: The practice provides computerized reports or screen shots and one of the following two options showing use of information in the reports:

- A written description of the process
- Examples of use of the reports (see the bulleted list in the details).

¹CPT codes copyright 2005 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

PPC 3: Care Management**20.00 points**

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patients' care.

Intent

The practice maintains continuous relationships with patients by implementing evidence-based guidelines and applying them to the identified needs of individual patients over time and with the intensity needed by the patients.

Element A: Guidelines for Important Conditions**3.00 points**

The practice adopts and implements evidence-based diagnosis and treatment guidelines for:

Yes No

1. First clinically important condition
2. Second clinically important condition
3. Third clinically important condition.

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice implements guidelines for 3 conditions	No scoring option	Practice implements guidelines for 2 conditions	Practice implements guidelines for 1 condition	Practice does not implement guidelines for any conditions

Data source

Materials

Scope of review

ONCE—NCQA scores this element once for the organization.

Explanation**IT required:** Basic**Condition-specific:** Yes

Details: The physicians in the practice adopt evidence-based guidelines and use them. The practice's guidelines must cover three clinically important conditions for its population. The practice's workflow organizers ensure that the guidelines are meaningful to the clinicians in the practice and that they are consistent with the standards of care that the practice wants to follow.

In the Support Text/Notes the practice states the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

Practices will use the same three clinically important conditions for Elements 2D, 2E, 3A, 3D, 4B and 9C.

When identifying the "first clinically important condition," the "second clinically important condition" and the "third clinically important condition," practices are not indicating any kind of hierarchy among the three.

See PPC 2E (explanation) for additional information on selecting clinically important conditions.

- Examples** **Data source:** Workflow organizers, which demonstrate both adoption and implementation of guidelines by the practice.
- Paper-based organizers—algorithms for developing treatment plans, flow sheets or templates for documenting progress.
 - Electronic system organizers (registry, EHR or other system)—screenshots showing templates for treatment plans and documenting progress.

Element B: Preventive Service Clinician Reminders **4.00 points**

The practice uses a paper-based or electronic system with guideline-based reminders for the following services when seeing the patient:	Yes	No	NA
1. Age-appropriate screening tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Age-appropriate immunizations (e.g., influenza, pediatric)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Age-appropriate risk assessments (e.g., smoking, diet, depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Counseling (e.g., smoking cessation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses reminders for 4 items	Practice uses reminders for 3 items	Practice uses reminders for 2 items	Practice uses reminders for 1 item	Practice uses reminders for no items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic if paper-based system, intermediate if electronic system
Condition-specific: No
Details: This element requires using alerts and reminders across the practice for patients who need particular services. The practice identifies patients by age, gender and status of preventive services, and prompts the clinician at the point of care. The following are examples of types of alerts and reminders:

- Order mammogram.
- Assess smoking status and give cessation advice or treatment. “Counseling” includes anticipatory guidance.
- Immunizations as per AAP/AAFP/CDC (ACIP) recommendations.

A practice could indicate that a factor is not applicable if the practice's specialties are not involved with providing preventive services for patients. For example, some surgical specialties may not be involved with identifying and providing reminders for screening tests or age-appropriate immunizations.

Examples **Data source example:** Documentation from an electronic system may include reports or screen shots.
 Documentation from a paper-based system may include templates, flow sheets, algorithms or reminders.
 The practice must show that its clinicians have available decision support for interactions with patients including in-person appointments, telephone calls and e-mail communication.

Element C: Practice Organization	3.00 points
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	Yes	No
The care team manages patient care in the following ways:		
1. Nonphysician staff remind patients of appointments and collect information prior to appointments	<input type="checkbox"/>	<input type="checkbox"/>
2. Nonphysician staff execute standing orders for medication refills, order tests and deliver routine preventive services	<input type="checkbox"/>	<input type="checkbox"/>
3. Nonphysician staff educate patients/families about managing conditions	<input type="checkbox"/>	<input type="checkbox"/>
4. Nonphysician staff coordinate care with external disease management or case management organizations.	<input type="checkbox"/>	<input type="checkbox"/>

	100%	75%	50%	25%	0%
Scoring	Staff manage 4 items	Staff manage 3 items	Staff manage 2 items	No scoring option	Staff manage 0-1 items

Data source Materials

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic

Condition-specific: No

Details: While physicians are responsible for directing and coordinating patient care, managing patient care is usually a team effort that involves all members of the practice who interact with patients (i.e., physicians, nurses, allied health personnel/care coordinator/family partner). The practice uses a team approach in managing patient care. Shared responsibilities are designed to maximize use of each team member's level of training and expertise. In small practices, this may be designated roles for the physician, the nurse and the administrative person if there is one. In most practices, the availability of nurse case managers will only be through the patients' health plans or other large organization. In some practices physicians may handle significant patient care responsibilities, especially for complex patients. Disease management or care management may be provided internally by the practice or group or available to the patient externally, usually through the health plan.

Item 2—Standing orders can be physician pre-approved, or executed without physician prior approval, depending upon staff licensure, training or level of expertise. Examples of standing orders include standing test protocols, standing medication orders, and any standing order that nonphysician staff will carry out.

Examples **Data source:** Job descriptions, protocols, written standing orders.

Element D: Care Management for Important Conditions 5.00 points

For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:

1. Conducting pre-visit planning with clinician reminders
2. Writing individualized care plans
3. Writing individualized treatment goals
4. Assessing patient progress toward goals
5. Reviewing medication lists with patients
6. Reviewing self-monitoring results and incorporating them into the medical record at each visit
7. Assessing barriers when patients have not met treatment goals
8. Assessing barriers when patients have not filled, refilled or taken prescribed medications
9. Following up when patients have not kept important appointments
10. Reviewing longitudinal representation of patient’s historical or targeted clinical measurements
11. Completing after-visit follow-up.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75% or more of patients seen in the past 3 months have at least 4 items documented	50-74% of patients seen in the past 3 months have at least 4 items documented	25-49% of patients seen in the past 3 months have at least 4 items documented	11-24% of patients seen in the past 3 months have at least 4 items documented	10% or fewer patients seen in the past 3 months have at least 4 items documented

Data source Records or files

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Source of content: IOM
Condition-specific: Yes

Details: This element is scored once, from a sample across all three important conditions. In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

Not all patients with important conditions require care management, and those that do require it can benefit from all of the actions called for in this element. The physician may decide that patients already achieving good outcomes do not require care management; in those cases, a notation that the patient has good outcomes would suffice in place of a record of the care management processes.

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

Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

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

Method 2—Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see Element 2E).

- Denominator = The sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = The patients from the medical record review for whom at least four items are entered.

Item 2—Written care plans address the respective responsibilities of the medical home and specialists to whom the practice has referred the patient.

Items 7–9—Barriers to be addressed may include the patients' lack of understanding, motivation, financial need, insurance issues or transportation problems.

Item 9—Important appointments are those that the practice has requested the patient to make in order to follow standards of care (e.g., follow-up visits for monitoring blood pressure or blood sugar levels). Examples of after-visit follow up (Item 11) may include checking with patients to confirm they filled a prescription or received care with a consultant.

Examples of longitudinal of patient data (Item 10) may include graphs or flow sheets showing blood pressure, weight or LDL levels over time.

Records may show that the practice performs these functions via phone, individual visits, group visits, e-mail or some combination of these. The practice may also utilize another organization, such as a disease management organization, to perform these functions.

Examples **Data source:** Medical record showing the components of care management.

Element E: Continuity of Care **5.00 points**

	Yes	No
The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care:		
1. Identifies patients who receive care in facilities	<input type="checkbox"/>	<input type="checkbox"/>
2. Systematically sends clinical information to the facilities with patients as soon as possible	<input type="checkbox"/>	<input type="checkbox"/>
3. Reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes	<input type="checkbox"/>	<input type="checkbox"/>
4. Contacts patients after discharge from facilities	<input type="checkbox"/>	<input type="checkbox"/>
5. Provides or coordinates follow-up care to patients/families who have been discharged	<input type="checkbox"/>	<input type="checkbox"/>
6. Coordinates care with external disease management or case management organizations, as appropriate	<input type="checkbox"/>	<input type="checkbox"/>
7. Communicates with patients/families receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input type="checkbox"/>
8. Communicates with case managers for patients receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input type="checkbox"/>
9. For patients transitioning to other care, develops a written transition plan in collaboration with the patient and family	<input type="checkbox"/>	<input type="checkbox"/>
10. Aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation.	<input type="checkbox"/>	<input type="checkbox"/>

	100%	75%	50%	25%	0%
Scoring	Activities include 5-10 items	Activities include 3-4 items	Activities include 2 items	No scoring option	Activities include 0-1 items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Condition-specific: No
Details: When the need for facility care is anticipated (i.e., when not an emergency), the practice provides the facility with appropriate information. The practice or external organization reviews data to identify patients who receive inpatient or outpatient care at a facility. A facility may be a hospital, an emergency room, a skilled nursing facility or a surgical center. The practice does not wait for these patients to make an appointment, but contacts them directly. Proactive contact includes assisting patients with appropriate care to prevent worsening of their conditions. After the practice has contacted patients, it ensures they receive follow-up care as necessary. Examples of follow-up care include, but are not limited to, physician counseling, referrals to community resources, disease or case management or self-management support programs.

When a patient requires disease management or case management due to frequent emergency room visits, frequent hospitalizations, clinically important conditions or other reason, the practice maintains continuity of care by regularly communicating with both the patient and the case manager. The practice or external organization has a written protocol describing the schedule for communication and at least one example showing the frequency of communication between case manager and patient and one example of case manager and physician. Youth and family receive coordination and support to link their health and transition plans with other relevant adolescent and adult practitioners.

Examples

Data source: May be from the practice itself or from an external case management organization such as a disease management organization with which the practice works. The data sources may include:

- Protocols that include the practice's timeframe for patient follow up after an admission or emergency room visit
- Protocols for using care plans and patient visit flow sheets
- Printout from registry, EHR, hospital emergency room, admitting department or other computerized reports that include a list of identified patients, emergency room visits and inpatient admissions
- Manual or electronic patient health/needs assessments
- Blinded case management or medical record notes.

PPC 4: Patient Self-Management Support

6.00 points

The practice works to improve patients' ability to self-manage health by providing educational resources and ongoing assistance and encouragement.

Intent

The practice collaborates with patients and families to pursue their goals for optimal achievable health.

Element A: Documenting Communication Needs

2.00 points

The practice assesses patient/family-specific barriers to communication using a systematic process to:

Yes No

1. Identify and display in the record the language preference of the patient and family

2. Assess both hearing and vision barriers to communication.

Scoring

100%	75%	50%	25%	0%
Practice assesses 2 items	No scoring option	Practice assesses 1 item	No scoring option	Practice does not assess any items

Data source Documented process, Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic

Condition-specific: No

Details: For this element, the practice provides documentation of a systematic process for prompting clinicians to assess language preference and hearing and vision communication barriers. This element requires a systematic process that does not depend on practice staff remembering to assess the issues—the paper or electronic system prompts the practice's staff member to do so.

The practice should provide documentation that shows it identifies language preference using a paper-based or electronic systematic process that prompts the practice staff to get the information from the patient or family. Census bureau information to identify language preference does not meet the intent of this item.

Examples

Data source: Documents that show how the practice records language preference (e.g., screen shots, patient assessment forms) and how the practice determines the percentage of its patients that prefer another language (e.g., reports from an electronic system, review of a sample of records).

Health literacy is a major barrier to quality care and is the subject of current NCQA research. The results of this research will inform future versions of PPC-PCMH.

Element B: Self-Management Support**4.00 points**

The practice conducts the following activities to support patient/family self-management, for the three important conditions:

1. Assesses patient/family preferences, readiness to change and self-management abilities
2. Provides educational resources in the language or medium that the patient/family understands
3. Provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients/families to record results in the home setting where applicable
4. Provides or connects patients/families to self-management support programs
5. Provides or connects patients/families to classes taught by qualified instructors
6. Provides or connects patients/families to other self-management resources where needed
7. Provides written care plan to the patient/family.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75%-100% of patients seen in the past 3 months have at least 3 activities documented	50%-74% of patients seen in the past 3 months have at least 3 activities documented	25%-49% of patients seen in the past 3 months have at least 3 activities documented	11%-24% of patients seen in the past 3 months have at least 3 activities documented	10% or less patients seen in the past 3 months have at least 3 activities documented

Data source Records or files

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic

Condition-specific: No

Details: This element addresses the practice helping patients manage their health. This element goes beyond physician counseling or guidance during an office visit. The practice or its medical group may provide self-management programs or classes or the practice may refer the patient to community resources, when needed and available. The resources to where the practice refers patients may include resources that the practice knows are provided by the patient's health plan.

Written materials for patients should be appropriate for patients with low levels of literacy (5th grade reading level).

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

Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

- Denominator = Total number of patients with one of the three clinically important conditions seen at least once by the practice in the last three months
- Numerator = Number of patients for whom each item is entered.

Method 2—Review a sample of 36 medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of 36 relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see element 2E).

- Denominator = The sample of 36 patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = The patients from the medical record review for whom at least three items are entered.

Not all patients with important conditions require self-management support, and those that do require it can benefit from all of the actions called for in this element. The physician may decide that patients already achieving good outcomes do not require self-management support; in those cases, a notation that the patient has good outcomes would suffice in place of a record of the self-management items in this element.

Examples of Item 1, assessing readiness to change, include questionnaires and self-assessment forms. Examples of Item 2 include a copy of the educational materials the practice has available for patients does not meet the intent of this item. The medical record must also indicate that the practice has provided materials to the patient.

Examples of Item 4, self-management programs, include weight loss and smoking cessation programs.

Examples of Item 5, classes taught by instructors, include diabetes and asthma education.

Examples of Item 7, other self management resources, include group visits, counseling and support groups.

Examples

Data source: Medical record review includes:

- Referrals to programs, classes or other self-management resources from the patient record
- Use of tool for assessing patient preferences, readiness to change and self-management abilities
- Use of educational brochures, pamphlets and video
- Self-monitoring tool or personal health record
- Referrals to community resources.

PPC 5: Electronic Prescribing**8.00 points**

The practice employs electronic systems to order prescriptions, to check for safety and to promote efficiency when prescribing.

Intent

The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions and by using drug safety checks and cost information when prescribing.

Element A: Electronic Prescription Writing**3.00 points**

The practice uses an electronic system to write prescriptions using either:

1. Electronic prescription writer—stand-alone system (general) with either print capability at the office or ability to send fax or electronic message to pharmacy
2. Electronic prescription writer that is linked to patient-specific demographic and clinical information.

Select the choice that most closely reflects the practice's performance.

- 75-100% of new prescriptions for patients seen in the last 3 months written with Item 2
- 75-100% of new prescriptions for patients seen in the last 3 months written with Item 1
- Practice has system capable of doing either Item 1 or Item 2, but practice does not use
- System does not have capability or less than 75% of prescriptions written with Item 1 or Item 2

Scoring

100%	75%	50%	25%	0%
75-100% of new prescriptions for patients seen in the last 3 months written with Item 2	75-100% of new prescriptions for patients seen in the last 3 months written with Item 1	No scoring option	Practice has system capable of doing either Item 1 or Item 2, but practice does not use	System does not have capability or less than 75% of prescriptions written with Item 1 or Item 2

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Intermediate

Source of content: *Electronic Prescribing: Toward Maximum Value and Rapid Adoption, A Report of the Electronic Prescribing eHealth Initiative, April 14, 2004*

Condition-specific: No

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

- Denominator = Total number of prescriptions written for patients in the last 3 months
- Numerator = Number of new prescriptions written with the practice's prescribing system.

Prescription renewals may count as "new" prescriptions. If all of the practice's prescriptions are written electronically, the practice must provide a report showing use of the system for a specified percentage of patients.

The term **general** in all the prescribing elements refers to information about medications from standard data bases. The term **patient-specific** refers to information that is related or linked to data on a particular patient. The e-prescribing system includes e-faxing as long as it is not a hand-written prescription.

Examples **Data source:** Reports from system.

Element B: Prescribing Decision Support—Safety

3.00 points

Clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, including the following types of alerts and information:

1. Drug-drug interactions based on general information
2. Drug-drug interactions specific to drugs the patient takes
3. Drug-disease interactions based on general information
4. Drug-disease interactions specific to diseases the patient has
5. Drug-allergy alerts based on general information
6. Drug-allergy alerts specific to the patient
7. Drug-patient history alerts based on general information
8. Appropriate dosing based on general information
9. Appropriate dosing calculated for the patient
10. Therapeutic monitoring associated with specific drug utilization based on general information (drug-lab alerts)
11. Duplication of drugs in a therapeutic class based on general information
12. Duplication of drugs in a therapeutic class specific to the patient
13. Drugs to be avoided in the elderly based on general information
14. Drugs to be avoided in the elderly based on age of the patient
15. Patient-appropriate medication information.

- Practice uses 8 or more kinds of alerts and information
- Practice uses 4 to 7 kinds of alerts and information
- Practice uses 2 to 3 kinds of alerts
- System has capability of providing 6 or more kinds of alerts, but practice does not use them
- No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

	100%	75%	50%	25%	0%
Scoring	Practice uses 8 or more kinds of alerts and information	Practice uses 4 to 7 kinds of alerts and information	Practice uses 2 to 3 kinds of alerts	System has capability of providing 6 or more kinds of alerts, but practice does not use them	No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Advanced if practice obtains patient-specific data on filled prescriptions; Intermediate for all general alerts and for patient-specific alerts using internal data on prescribed medications.

Source of content: eHealth Initiative, US Pharmacopoeia

Condition-specific: No

Details: The practice's electronic system should alert clinicians to specific prescribing issues for patient safety.

Addressed by this element are:

- Stand-alone electronic prescription reference tools that provide **general** automatic alerts—these could meet the factors that call for general information
- Electronic prescription writers or EHRs that provide **general** automatic alerts—these could also meet the factors that call for **general** information
- Electronic prescription writers or EHRs that provide **patient-specific** drug and medication management information. These utilize a list of medications a patient is taking, as well as other patient-specific information to generate alerts. These tools should also generate alerts based on general information, as the clinician can not assume that all needed patient-specific information is available electronically in the practice's system. Patients may have history, diagnoses or medications that the practice's system has not captured.

NCQA has first-year HEDIS specifications for Items 10 and 13. In the future, national organizations may provide more specifications to standardize some of these types of alerts. Systems should have the capability of adding specific alerts as specifications become available.

Examples **Data source:** Reports from the system, paper or electronic, showing an example of use of each item.

Element C: Prescribing Decision Support—Efficiency 2.00 points

Clinicians engage in cost-efficient prescribing through one or more of the following tools:

1. Electronic prescription writer with general automatic alerts for different choices including generics
2. Electronic prescription writer connected to payer-specific formulary that automatically alerts clinician to alternative drugs, including generics.

Select the choice that most closely reflects the organization's performance.

- Practice uses 2 tools
- Practice uses 1 tool
- System has capability to support both options; practice does not use it
- System does not have capability or practice does not use either tool

Scoring	100%	75%	50%	25%	0%
	Practice uses 2 tools	Practice uses 1 tool	No scoring option	System has capability to support both options; practice does not use it	System does not have capability or practice does not use either tool

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Advanced if checks are patient-specific (requires connection to formulary); Intermediate if checks are general.

Condition-specific: No

Details: The practice's electronic system should alert the clinician to the most cost-effective of the choices for the patient, including generic drugs. The most effective type of tool actually connects with or downloads the formulary for the patient's health plan, to alert the clinician to the most efficient choice for the patient.

Examples **Data source:** Reports from the system, screen shots, practice protocols.

PPC 6: Test Tracking**13.00 points**

The practice systematically tracks tests ordered and test results, and systematically follows up with patients.

Intent

The practice works to improve effectiveness of care, patient safety and efficiency by using timely information on all tests and results.

Element A: Test Tracking and Follow-Up**7.00 points**

The practice systematically tracks tests and follows up in the following manner:

1. Tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
2. Tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
3. Flags abnormal test results, bringing them to a clinician's attention
4. Follows up with patients/families for all abnormal test results
5. Follows-up with inpatient facility on hearing screening and metabolic screening to get results
6. Notifies patients/families of all normal test results.

Select the choice that most closely reflects the practice's performance.

- Practice does 4-6 types of tracking and follow-up
- Practice does 3 types of tracking and follow-up
- Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it
- Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Scoring

100%	75%	50%	25%	0%
Practice does 4-6 types of tracking and follow-up	No scoring option	Practice does 3 types of tracking and follow-up	Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it	Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic if paper system, intermediate if electronic system within the office, advanced if interconnected with laboratory or radiology.

Condition-specific: No

Details: Whether the system is manual or electronic, there must be evidence that the practice reviews and uses the log before or at the beginning of every patient appointment. There must be evidence that the practice both follows up with the clinician and proactively notifies the patient of abnormal results; filing the report in the medical record for the next time the patient comes in does not meet the intent of the standard.

Examples **Data source:** Reports or logs—may be a paper log or an electronic in-box showing outstanding tests and showing how the practice flags abnormal results.

Element B: Electronic System for Managing Tests 6.00 points

The practice uses an electronic system to:	Yes	No
1. Order lab tests	<input type="checkbox"/>	<input type="checkbox"/>
2. Order imaging tests	<input type="checkbox"/>	<input type="checkbox"/>
3. Retrieve lab results directly from source	<input type="checkbox"/>	<input type="checkbox"/>
4. Retrieve imaging text reports directly from source	<input type="checkbox"/>	<input type="checkbox"/>
5. Retrieve images directly from the source	<input type="checkbox"/>	<input type="checkbox"/>
6. Route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison	<input type="checkbox"/>	<input type="checkbox"/>
7. Flag duplicate tests ordered	<input type="checkbox"/>	<input type="checkbox"/>
8. Generate alerts for appropriateness of tests ordered.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses 5-8 functions	Practice uses 3-4 functions	Practice uses 1-2 functions	No scoring option	Practice does not use system

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Advanced

Condition-specific: No

Details: This element assumes electronic communication between the practice and the lab and imaging facilities, as well as electronic alerts generated by or for the practice.

If the practice has electronic capability to manage tests but has not used it, it may receive an override score of 25%.

Examples **Data source:** Reports or screen shots from the system showing examples of each of the functions.

PPC 7: Referral Tracking

4.00 points

The practice systematically documents and tracks referrals and referral results.

Intent

The practice seeks to improve effectiveness, timeliness and coordination of care by following through on consultations with other practitioners.

Element A: Referral Tracking

4.00 points

Outside of paper medical records and patient visits, the practice uses a paper-based or electronic system to assist in tracking practitioner referrals designated as critical until the specialist or consultant report returns to the practice. The practice uses a system that includes the following information for its referrals:

	Yes	No
1. Origination	<input type="checkbox"/>	<input type="checkbox"/>
2. Clinical details	<input type="checkbox"/>	<input type="checkbox"/>
3. Tracking status	<input type="checkbox"/>	<input type="checkbox"/>
4. Administrative details.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice uses system that includes all 4 items	Practice uses system that includes 2-3 items	Practice uses system that includes 1 item	No scoring option	System does not include any of the items

Data source

Reports

Scope of review

ONCE—NCQA scores this element once for the organization.

Explanation

IT required: Basic or Advanced (Basic for paper system; Advanced for electronic system).

Source of content: HL-7 functional standards

Condition-specific: No

Details: Origination includes the referring clinician (the origin of the referral).

Clinical details include the clinical reason for requesting the referral as well as relevant clinical information. This may include:

- Reason for the consultation
- Pertinent clinical findings
- Support person
- Functional status
- Family history
- Social history
- Plan of care
- Health care providers.

Administrative details include insurance information, including whether the referral requires health plan approval.

Tracking status includes whether or not the consultant report has returned to the practice.

A critical referral is determined by the physician to be important to the treatment of the patient or indicated by practice guidelines. An example would be a referral to a breast surgeon for examination of a possibly cancerous lump or a referral to a mental health professional for a patient identified with depression or suicidal ideation. As many patients with special health care needs receive care regularly from a specialist or consultant, it is essential that the practice remain engaged in that care. The practice should establish an effective mechanism of timely communication with the specialist or consultant either by phone, fax or e-mail in addition to written correspondence.

Examples

Data source: Written logs or other paper-based documents if not electronic, reports from the system if electronic.

PPC 8: Performance Reporting and Improvement**15.00 points**

The practice regularly measures its performance and takes actions to continuously improve.

Intent

The practice seeks to improve effectiveness, efficiency, timeliness and other aspects of quality by measuring and reporting performance, comparing itself to national benchmarks, giving physicians regular feedback and taking actions to improve.

Element A: Measures of Performance**3.00 points**

The practice measures or receives data on the following types of performance by physician or across the practice:

	Yes	No
1. Clinical process (e.g., percentage of women 50+ with mammograms or childhood vaccination rates)	<input type="checkbox"/>	<input type="checkbox"/>
2. Clinical outcomes (e.g., HbA1c levels for diabetics)	<input type="checkbox"/>	<input type="checkbox"/>
3. Service data (e.g., backlogs or wait times)	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient safety issues (e.g., medication errors).	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

	100%	75%	50%	25%	0%
	Practice measures at least 2 types of performance	No scoring option	Practice measures 1 type of performance	No scoring option	No areas of performance measured

Data source

Reports

Scope of review

ONCE—NCQA scores this element once for the organization.

Explanation**IT required:** Basic**Condition-specific:** No

Details: Performance reports may be generated by the individual practice site, the medical group or individual practice association to which the practice belongs or an affiliated health plan.

The practice may use electronic systems to measure any of these items, but the element requires performance measurement whether or not electronic systems are available. Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not only those covered by one payer.

Practices with NCQA's Heart Stroke (HSRP) Recognition or Diabetes Physician (DPRP) Recognition may receive credit for measuring Item 1, clinical process and Item 2, clinical outcomes performance data. To receive credit, the HSRP and/or DPRP Recognition dates must be current at the time the practice submits its PPC-PCMH Survey Tool to NCQA. The practice should enter this information in the Support Text/Notes in the Survey Tool.

Examples

Data source: Reports from:

- Manual review of a sample of patient records
- Patient surveys
- Practice management system
- Registry
- Health plan-provided data
- Larger medical group provided data
- Electronic database.

Element B: Patient Experience Data 3.00 points

The practice collects data on patient experience with care in the following areas:	Yes	No
1. Patient access to care	<input type="checkbox"/>	<input type="checkbox"/>
2. Quality of physician communication	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient/family confidence in self care	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient/family satisfaction with care.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice collects data on 3-4 areas	No scoring option	Practice collects data on 1-2 areas	No scoring option	Practice do not collect data in any areas

Data source

Reports

Scope of review

ONCE—NCQA scores this element once for the organization.

Explanation

IT required: Basic

Condition-specific: No

Details: Practices may use a phone survey or a paper or electronic survey. Patient access to care may include the ability to make an appointment and see a physician, timeliness and quality of phone calls, office wait time. Quality of physician communication may include response to questions, instructions and information about diagnosis, treatment, medication and follow up care. Practices may also incorporate questions about the degree to which patients and families feel that they are partners in the management of their health care.

Patient/family confidence in self-care may include patient knowledge of and ability to provide self-care involving activity, exercise, medications and reporting change in symptoms. Patient/family satisfaction with care may include satisfaction with staff, physician and others, satisfaction with treatment and satisfaction with response to patient/family choices. Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not only those covered by one payer.

Practices may qualify for 50 percent of points if they demonstrate that they have established a patient advocacy group or patient advisory board that meets periodically. Practices must provide documentation that such meetings are used to gather patient feedback.

Note: Practices must provide summarized data. A blank survey form does not meet the intent of this requirement.

Examples **Data source:** Reports or completion of the PPC-PCMH Quality Measurement and Improvement worksheet.

Element C: Reporting to Physicians	3.00 points
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The practice reports on performance on the measures in 8A and 8B:	Yes	No
1. Across the practice	<input type="checkbox"/>	<input type="checkbox"/>
2. By individual physician.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

100%	75%	50%	25%	0%
Practice reports to physicians results both across the practice and by physician	No scoring option	Practice reports to physicians results either across the practice or by physician	No scoring option	No areas of performance reported to physicians

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Condition-specific: No
Details: The practice may utilize data that it produces itself or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plans. Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not just those covered by one payer. After the practice measures or receives performance data, it reports it to the practice as a whole and to individual physicians. Practices have found meetings of physicians and staff to be an effective way to process and improve performance results.

Examples **Data source:** Blinded reports showing summary practice performance or individual physician performance; blinded letters to physicians showing performance.

Element D: Setting Goals and Taking Action **3.00 points**

The practice uses performance data to:	Yes	No
1. Set goals based on measurement results referenced in Elements 8A and 8B.	<input type="checkbox"/>	<input type="checkbox"/>
2. Take action where identified to improve performance of individual physicians or of the practice as a whole.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice does 2 items	No scoring option	Practice does 1 item	No scoring option	Practice does no items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT required:** Basic
Condition-specific: No
Details: The practice should base goal setting on its own measurements as in element 8A. Examples of actions taken include providing such assistance as flow sheets or decision support to clinicians to prompt more systematic treatment. Goal setting and taking action include periodic remeasurement to assess progress and promote continuous quality improvement. Practices may find it useful to involve patients and families in quality improvement activities.

Examples **Data source:** Reports or completion of the PPC-PCMH Quality Measurement and Improvement worksheet.

Element E: Reporting Standardized Measures **2.00 points**

The practice produces reports on its performance using nationally approved clinical performance measures.

[In the box to the right, enter the number of measures]

Scoring	100%	75%	50%	25%	0%
	Practice produces reports using 10 or more nationally approved performance measures	Practice produces reports using 5-9 nationally approved performance measures	Practice produces reports using 3-4 nationally approved performance measures	No scoring option	Practice produces reports using 0-2 nationally approved performance measures

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation IT required: Intermediate**Condition-specific:** No

Details: The intent is that the practice both measures and has the capability to report performance using measures that are endorsed by the National Quality Forum (NQF). As national measure sets are evolving, the practice should have the ability to report current measures as well as to program the reporting of new measures. Measures that are currently endorsed by the National Quality Forum for use at the physician or practice level may be accessed on the NQF Web site <http://www.qualityforum.org/>.

Reporting these measures requires that the practice have the ability to link a variety of data sources, including:

- Standard ambulatory diagnoses and procedure codes (ICD, CPT)
- Prescribed medications
- Lab tests and results
- Radiology data (ordered, results)
- Blood pressure (value)
- Standard inpatient Diagnosis and Procedure codes (DRG, CPT, ICD).

Examples Data source: Reports showing performance measures calculated by practice.**Element F: Electronic Reporting—External Entities****1.00 points**

The practice electronically reports results on nationally approved measures to the public sector, health plans or others.

[In the box to the right, enter the number of measures]

Scoring

100%	75%	50%	25%	0%
Practice transmits 10 or more nationally approved performance measures to an external entity	Practice transmits at least 5-9 nationally approved performance measures to an external entity	Practice transmits 3-4 nationally approved performance measures to an external entity	Practice transmits 1-2 nationally approved measures to an external entity	Practice does not transmit any measures

Data source Reports**Scope of review** ONCE—NCQA scores this element once for the organization.

Explanation	<p>IT required: Advanced</p> <p>Condition-specific: No</p> <p>Details: This element assesses the practice's ability to report measures electronically to external entities.</p> <p>If the system has the capability to transmit measures but has not done so, the practice may receive an override score of 25%.</p>
Examples	<p>Data source: Report to payer or other user from practice's electronic system.</p>

PPC 9: Advanced Electronic Communication**4.00 points**

The practice uses electronic communication to communicate with patients/families and other care providers.

Intent

The practice maximizes use of electronic communication to improve timeliness, effectiveness, efficiency and coordination of care.

Element A: Availability of Interactive Web Site**1.00 points**

The practice provides patients/families with access to an interactive Web site that allows them to:

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Request appointments by reviewing clinicians schedules | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Request referrals | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Request test results | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Request prescription refills | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. See elements of their medical record | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Import elements of their medical record into a personal health record. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

100%	75%	50%	25%	0%
Practice provides 5-6 items	Practice provides 3-4 items	Practice provides 1-2 items	No scoring option	Practice does not provide any items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate

Condition-Specific: No

Details: This element looks at ways practices can provide Web-based functionality that support patient access and patient-self-management.

Examples **Data source:** Screen shots showing presence of Web-based functionality.

Element B: Electronic Patient Identification 2.00 points

The practice combines use of electronic information and clinical decision-support to contact the following types of patients, once identified, by e-mail:	Yes	No
1. Patients needing clinical review or action	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients on a particular medication	<input type="checkbox"/>	<input type="checkbox"/>
3. Patients needing preventive care	<input type="checkbox"/>	<input type="checkbox"/>
4. Patients needing specific tests	<input type="checkbox"/>	<input type="checkbox"/>
5. Patients needing follow up visits	<input type="checkbox"/>	<input type="checkbox"/>
6. Patients who might benefit from disease or case management support.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses electronic information and communication for 5-6 items	Practice uses electronic information and communication for 3-4 items	Practice uses electronic information and communication for 1-2 items	No scoring option	Practice does not use electronic information for any items

Data source	Reports
Scope of review	ONCE—NCQA scores this element once for the organization.
Explanation	<p>IT required: Intermediate</p> <p>Condition-specific: No</p> <p>Details: This element requires the practice to use electronic information to communicate with the patient by e-mail about specific needs.</p>
Examples	Data source: Screen shots showing identification of patients for the above items and an example of e-mail communication with patients based on electronic identification.

Element C: Electronic Care Management Support**1.00 points**

For patients with the three clinically important conditions, the practice care management team uses electronic communication for the following:

Yes No

1. To communicate with disease or case managers about patient needs
2. Web-based educational modules for patient self-management.

Scoring

100%	75%	50%	25%	0%
Practice uses electronic communication for 2 items	Practice uses electronic communication for 1 item	No scoring option	No scoring option	Practice does not use electronic communication for any items

Data source

Reports

Scope of review

ONCE—NCQA scores this element once for the organization.

Explanation**IT required:** Intermediate**Condition-specific:** No

Details: This element identifies ways in which practices can use electronic communication to support the care management process. Web-based education modules may be on the practice Web site or through an arrangement with, and referral to, others.

Examples

Data source: Screen shots showing electronic communication about care management. Screen shots or links to education modules.

Appendix 1

Joint Principles of the Patient-Centered Medical Home

APPENDIX 1

JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

February 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information

- American Academy of Family Physicians: <http://www.futurefamilymed.org>
- American Academy of Pediatrics: http://aappolicy.aappublications.org/policy_statement/index.dtl#M
- American College of Physicians: <http://www.acponline.org/advocacy/?hp>
- American Osteopathic Association: <http://www.osteopathic.org>

Appendix 2

PPC-PCMH Pricing

APPENDIX 2

PPC-PCMH VERSION—PRICING

Standard Survey Pricing

The Full Survey price is the fee for physician practices undergoing the process for the first time and at the time of renewal.

Number of Physicians in the Practice	Initial Fee for Practice to Obtain a Survey Tool License	Application Fees for NCOA Review and Recognition	Total License and Application Fees
1	\$80	\$450	\$530
2	\$80	\$900	\$980
3	\$80	\$1,350	\$1,430
4	\$80	\$1,800	\$1,880
5	\$80	\$2,250	\$2,330
6 +	\$80	\$2,700	\$2,780
>100	\$80	\$2,700 + \$10/ # >100	\$2,780 + \$10/ # >100

Discount for Sponsored Practices

NCQA offers a 20 percent discount from the Full Survey to applicants sponsored by health plans, employers and other programs. PPC-PCMH applicants receive the discount when the:

- Practice has 15 or fewer physicians, *and*
- Sponsor has ten or more applications in a market area within a twelve-month period.

Number of Physicians in Practice	Initial Fee for Practice to Obtain a Survey Tool License	Application Fees for NCOA Review and Recognition	Total License and Application Fees
1	\$80	\$360	\$440
2	\$80	\$720	\$800
3	\$80	\$1,080	\$1,160
4	\$80	\$1,440	\$1,520
5	\$80	\$1,800	\$1,880
6	\$80	\$2,160	\$2,240
7	\$80	\$2,520	\$2,600
8+	\$80	\$2,700	\$2,780

Add-On Survey Pricing

To advance to a higher PPC-PCMH Recognition level (i.e., from Level 1 to Level 2 or Level 3, or from Level 2 to Level 3), the practice applies for an add-on survey. This does not require the purchase of an additional PPC-PCMH Survey Tool; NCQA provides the Practice with a Survey Tool based on their previous submission. The application fee for NCQA review and Recognition of an add-on survey is discounted at the 50 percent level of the standard application fees.

Number of Physicians in Practice	Add-On Survey Application Fee
1	\$225
2	\$450
3	\$675
4	\$900
5	\$1,125
6+	\$1,350

Multi-Site Group Survey Pricing

Note: The practice may use only one PPC-PCMH pricing discount for a survey. If the practice uses a sponsored discount, it may not also use the Multi-Site Group Survey discount.

Several practice sites that share a common system or process may be eligible for an NCQA Multi-Site Group Survey; contact NCQA to apply. If NCQA determines that a practice is one of a group of practices eligible for a Multi-Site Group Survey, then the practice group purchases a Survey Tool for each practice site, plus an additional Survey Tool for the Multi-Site Group Survey. NCQA reviews the PPC elements approved for the shared processes or systems first (the Multi-Site Group Survey), then applies the Multi-Site Group Survey results to all practice sites in the multi-site group. The remaining elements are completed for each practice site.

NCQA offers a multi-site group discount to practices applying for a Full Survey. To receive a multi-site group discount on Full Surveys, the individual practice sites must submit Survey Tools for the PPC-PCMH evaluation process within six months of submitting the multi-site group Survey Tool.

There is a discount of 50 percent on the Full Survey fee for practices applying under a Multi-Site Group Survey. That is, the price for the Multi-Site Group Survey = Multi-Site Group Survey application fee from the table below with a 50 percent discount on the Full Survey application fees for each practice site + Survey Tool purchases for each site and the Multi-Site Group Survey.

Number of Practice Sites Within a Practice Group	Multi-Site Group Survey Application Fee
1	NA
2–5	\$1,000
6–10	\$2,000
> 10	\$3,000

Number of Physicians at a Practice Site	Practice Fee
1	\$225
2	\$450
3	\$675
4	\$900
5	\$1,125
6+	\$1,350

Reconsideration

A practice may seek Reconsideration of a recognition status decision, as described in the *Policies and Procedures*. A fee of \$500 per site will be charged, payable when the practice requests Reconsideration.

Appendix 3

Glossary

APPENDIX 3

PPC-PCMH GLOSSARY

allergy	An adverse reactions to a substance.
business associate	A person or organization that on behalf of a covered entity (health plan, health care clearinghouse or health care provider) or organized health care arrangement, which includes a covered entity, performs or assists in the performance of, but not in the capacity of a workforce member, functions or activities involving the use or disclosure of individually identifiable health information from the covered entity or organized health care arrangement.
clinical visit data	A record of patient activity at the practice.
clinically important condition	A chronic or recurring condition that a practice sees most frequently, such as otitis media, asthma, diabetes or congestive heart failure. The most frequently seen single-episode conditions may also be clinically important conditions such as colds or urinary tract infections.
contact information	Patient location facts that may include telephone number, e-mail address, payer ID and emergency contact information.
demographic information	Information that includes at least ethnicity, gender, marital status, date of birth, type of work, hours of work and preferred language.
diagnoses	A problem list of conditions, injuries or other health issues.
documented process	Written statements describing the practice's procedures. The statements may include protocols or other documents that describe actual processes or blank forms the practice uses in work flow such as referral forms, checklists and flow sheets.
Emergency admission	An unscheduled medical or behavioral health care event that results in either an emergency room visit or hospital admission.
evidence-based guideline	Clinical practice guidelines that are based on scientific evidence or, in the absence of scientific evidence, professional standards or, in the absence of professional standards, expert opinion. See practice guidelines .
example	A document, report or prepared material that illustrates implementation of systems or processes by the practice.
factor	An item within an element that is scored. For example, an element may require the organization to demonstrate that a specific document includes four items. Each item is a factor.
materials	Prepared material that the practice provides to patients, including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.
multi-site group	Multiple practice sites of a larger organization that provide standardized systems across the practices. In this case, NCQA reviews some elements once and applies the results to all practice sites in the Multi-Site Group.
must pass elements	Designated elements that a practice must pass at a 50% or greater score to achieve Recognition.

population management	The assessment of all patients in a practice to identify groups of patients who require specific services.
practice	One physician or a group of physicians at a single geographic location who practice together. Practicing together means that, for all the physicians in a practice: 1.) The single site is the location of practice for at least the majority of their clinical time; 2.) Nonphysician staff follow the same procedures and protocols; 3.) Medical records, whether paper or electronic, for all patients treated at the practice site are available to and shared by all physicians as appropriate; 4.) The same systems—electronic (computers) and paper-based—and procedures support both clinical and administrative functions: scheduling time, treating patients, ordering services, prescribing, keeping medical records and follow-up.
practice guidelines	Systematically developed descriptive tools or standardized protocols for care to support practitioner and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus. Practice guidelines may also be called <i>practice parameters</i> , <i>treatment protocols</i> or <i>clinical guidelines</i> .
preventive health data	A patient's status regarding receipt of preventive screenings, immunizations and counseling appropriate for the patient's age and gender.
records or files	Actual patient medial files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element. There are two ways to measure this performance: 1.) a query of electronic files yielding a count, and 2.) the sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook.
registry	A searchable list of patient data that the practice actively uses to assist in patient care.
reports	Aggregated data showing evidence of action; may include manual and computerized reports.
risk factors	Behaviors, habits, age, family history or other factors that may increase the likelihood of poor health outcomes.
sample	A statistically valid representation of the whole.
treatment plan	A written action plan based on assessment data that identifies the patient's clinical needs, the strategy for providing services to meet those needs, the treatment goals and objectives.

Appendix 4

PPC-PCMH Standards and Scoring

APPENDIX 4

PPC-PCMH STANDARDS AND SCORING

Standard 1: Access and Communication A. Has written standards for patient access and patient communication** B. Uses data to show it meets its standards for patient access and communication**	Pts 4 5 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with cost checks	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. Uses data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system D. Uses paper or electronic-based charting tools to organize clinical information** E. Uses data to identify important diagnoses and conditions in practice** F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 6 4 3 21	Standard 6: Test Tracking A. Tracks tests and identifies abnormal results systematically** B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts 7 6 13
Standard 3: Care Management A. Adopts and implements evidence-based guidelines for three conditions ** B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	Standard 7: Referral Tracking A. Tracks referrals using paper-based or electronic system**	PT 4 4
Standard 4: Patient Self-Management Support A. Assesses language preference and other communication barriers B. Actively supports patient self-management**	Pts 2 4 6	Standard 8: Performance Reporting and Improvement A. Measures clinical and/or service performance by physician or across the practice** B. Survey of patients' care experience C. Reports performance across the practice or by physician ** D. Sets goals and takes action to improve performance E. Produces reports using standardized measures F. Transmits reports with standardized measures electronically to external entities	Pts 3 3 3 3 2 1 15
Standard 9: Advanced Electronic Communications A. Availability of Interactive Website B. Electronic Patient Identification C. Electronic Care Management Support	Pts 1 2 1 4		

****Must Pass Elements**