Is it possible to earn NCQA Recognition without an EHR?

Yes. Although a practice can earn Level 1 or Level 2 PCMH recognition without an EHR, Level 2 recognition is easier to achieve with a basic EHR.

In order to earn the necessary points for Level 3 recognition and to generate the documentation demonstrating that the requirements for that level are met, a practice must use an EHR. Additionally, in order to meet all of the must-pass elements for any level of recognition, a practice must use a practice management system or registry.

What are the key differences between the 2008 and 2011 NCQA standards?


Changes in the PCMH 2011 standards include:

- An emphasis on patient-centeredness, linguistic and culturally sensitive aspects of care, integration of behaviors affecting health (e.g., obesity), substance abuse, mental health and enhanced coordination of care
- Alignment with the CMS meaningful use requirements
- Greater emphasis on evaluating patient/family experience of care, the importance of cost savings and the importance of using clinical performance measures in continuous quality improvement activities

PCMH 2011 has 6 standards and 6 must-pass elements that are required to achieve any level of recognition. PPC-PCMH 2008 has 9 standards and 10 must-pass elements but 5 of 10 are required for Level 1 Recognition and 10 of 10 for Levels 2 and 3.

How were the 2011 standards modified to be more relevant to pediatricians?

The term “patients/families” was incorporated throughout the 2011 standards, where appropriate, to address the importance of family-centered care. In addition, pediatric practice applicants may choose “N/A” on specific factors to avoid being penalized for items not relevant to pediatrics. Pediatric examples and explanations are included throughout the standards, as well as references to Bright Futures prevention guidelines, age-appropriate screenings and transition from pediatric to adult care.

Are there incentives to earning recognition at any level?

Yes but the availability of incentives depends on what is occurring in the market place where the practice is located. Some payers provide enhanced payments to practices that earn a specific NCQA Recognition level; others offer a preferred network status for recognition. In addition, there are multi-payer pilots or demonstration programs that test enhanced payment mechanisms, such as a pediatric initiative in Pennsylvania and the Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grants. Check with your AAP Chapter (http://www.aap.org/member/chapters/chaplist.cfm) or state Medicaid agency (http://www.namd-us.org/images/stories/namdpublicdirectory050911.pdf) to see if there are similar programs in your area, or if local carriers or Medicaid offer enhanced payments or have a preferred network status for recognized practices.

Practices have told NCQA that the changes resulting from becoming recognized lead to greater efficiency, improved clinician and staff satisfaction.
**Element A.2.3:** How does NCQA define “timely” phone or e-mail clinical advice? Are practices required to document response time?

NCQA leaves the definition of “timely” for the practice to decide, based on the needs of its population, but the practice must have a written policy for responding to calls and e-mails, which may categorize the types of requests and appropriate response times.

The practice must also monitor and demonstrate the policy’s implementation (e.g., a written policy on 24–48 hours for response to a nonurgent message, along with a report that shows a summary of response times.)


**Element B.1:** What does “regular business hours” mean? If a practice is open one evening a week, does this qualify as “outside of regular business hours”?

Yes, it qualifies if the practice already offers hours for urgent and routine appointments that accommodate the diverse scheduling needs for parents and families.

**Element C.1:** How does a practice account for adolescent confidentiality issues? For example, what if an adolescent specifically asks that information not be shared with a parent?

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


**Element C.3:** What constitutes an “electronic clinical summary”? What types of information are acceptable to meet this standard, including for well-child visits?

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

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

*Element C.3: Is a clinical summary necessary for acute care visits? It is likely that a patient will have almost recovered within three business days.*

Yes. A practice must document that clinical summaries are provided to patients for more than 50 percent of office visits, including acute care visits, within three business days.

Ideally, summaries are distributed immediately following the visit, but a three-day window is permitted under meaningful use requirements. The clinical summary for acute care visits could include warnings and instructions about prescriptions, complicating conditions, when to follow up, when to escalate the need for care and so on.

- **AAP Resources:** [Bright Futures Visit](http://brightfutures.aap.org/tool_and_resource_kit.html) Parent/Patient Education Handouts and Visit Documentation forms (spanning infancy, early childhood, middle childhood, and adolescent care visits):
- **AAP Consumer Education Brochures** (e.g., Common Childhood Infections, Acute Ear Infections and Your Child)

*Element D.1: Is there a specific threshold (or a specific percentage) of patients who are expected to have an identified personal physician?*

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

*Element D.3: Urgent care visits or visits during extended hours may not be available with the primary care clinician. Does NCQA prescribe the percentage that a practice must achieve?*

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

*Elements F.1.2: The standards state that information about linguistic needs of patients can be collected by the practice directly from all patients. For practices with a large patient population, is it acceptable to gather data from a random, representative sample of patients instead?*

No. Factors F1 and F2 ask practices to assess language needs and characteristics of its patient population. There are two methods a practice can use to meet this standard:

1. The practice may use data collected from all patients/families to create a report that shows the racial/ethnic composition and language needs of the practice.
2. Data may be obtained from an external source (e.g., data about the local community or its patient population).

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

**Resources**
- Medical Home Data Portal state pages: [http://medicalhomedata.org/content/Default.aspx](http://medicalhomedata.org/content/Default.aspx)
**Element F3: Where can I find pediatric-specific handouts in other languages?**

The intent of this standard is for practice to assess their population and determine whether handouts in specific languages might be necessary.

**AAP Resources**
- National Center for Medical Home Implementation Web site, Care Partnership Support resources on cultural competence and health literacy: [http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#culturally_competent](http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#culturally_competent)

**Other Resources**

**Element G.4.5.6.7: What constitutes adequate care team training?**

NCQA does not propose a specific method for training care team members; training should be specific to the services described in each factor and to the staff of the assigned team. It can be part of staff orientation or given at regularly scheduled intervals.

**AAP Resources**
- National Center for Medical Home Implementation Web site, Care Delivery Management page provides information and links to various resources regarding preparing office staff and creating medical home care teams: [http://www.medicalhomeinfo.org/how/care_delivery/#office](http://www.medicalhomeinfo.org/how/care_delivery/#office).
- The EQIPP: Medical Home for Pediatric Primary Care course helps pediatric health care providers create plans for improvement, and includes a module on developing a highly functioning, multidisciplinary quality improvement team: [http://www.pedialink.org/cmefinder/search-detail.cfm?key=C5D4B3AB-0A15-4C40-9AFD-DC9A70F099CB&type/course](http://www.pedialink.org/cmefinder/search-detail.cfm?key=C5D4B3AB-0A15-4C40-9AFD-DC9A70F099CB&type/course)

**Element G.7: Are there health literacy training programs tailored to pediatric practices?**

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

**AAP Resources**

**Other Resources:**
**PCMH 2: Identify and Manage Patient Populations**

*Element B.3: Our practice does not routinely take BP readings for 2-year-olds, per Bright Futures guidelines. Why does NCQA recommend BP screening for all children 2 years of age and older?*

NCQA aligned its standards and elements with Meaningful Use guidelines, which expect BP to be recorded in structured fields for all patients 2 years of age and older.

NCQA allows practices to define the age as “3 years of age and older” if they opt to meet only the NCQA requirement.

*Element D.1: Practices must generate lists of patients and use the lists to remind patients of at least three different needed preventive services or screenings, based on age.*

1. May a practice generate a list of pediatric patients from three age groups who are “behind” on similar preventive services? For example, could a practice pull a list of 2-year-olds, 6-year-olds and 12-year-olds who are behind on vaccinations?
2. Alternatively, could the practice generate lists of 2-year-olds who are behind on vaccinations, developmental screening and autism screening?

1. No. Practices must identify three *different* preventive care services, not just immunizations.
2. Yes. Vaccines, developmental screening and autism screening represent three different preventive care services.

**AAP Resources**

- **Recommendations for Preventive Pediatric Health Care (PDF):**
  [http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%2020101107.pdf](http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%2020101107.pdf)
- Interactive Periodicity Schedule (AAP Pediatric Care Online- Web resource):
  [https://www.pediatriccareonline.org/pco/ub/periodicity](https://www.pediatriccareonline.org/pco/ub/periodicity)

*Element C: What is the required frequency for a patient health assessment?*

Practices conduct patient assessments according to a protocol that suits their patient population. The element assesses the components and comprehensiveness of the patient assessment.

**AAP Resources:** Refer to the resources listed above for PCMH 2, D.1
**PCMH 3: Plan and Manage Care**

**Element A: Why does PCMH 3 focus on chronic conditions?**

Most pediatric population visits are related to well-child care. PCMH 3 focuses on conditions important to a practice’s patient population—the conditions may or may not be chronic. Practices may choose:

- One well-child cohort (specific age group)
- One important condition*, such as asthma or otitis media, and
- One condition related to unhealthy behaviors (e.g., obesity), mental health (e.g., depression, anxiety, ADHD) or substance abuse.

*Age-specific well-child care may only be chosen as one important condition. It should include care reflected in age-specific clinical guidelines, such as anticipatory guidance, nutrition guidance, immunizations and developmental screening—that is, whole child care, not just one-time monitoring or screening.

**AAP Resources**

- **Obesity Clinical Resources**: AAP Prevention and Treatment of Childhood Overweight and Obesity Web site: http://www.aap.org/obesity/clinical_resources.html?technology=0
- **National Heart, Lung, and Blood Institute (NHLBI) asthma guidelines**: http://www.nhlbi.nih.gov/guidelines/asthma/
- **Enhancing Pediatric Mental Health Care: Algorithms for Primary Care, Pediatrics 2010;125;S109** (More resources provided on the [AAP Task Force on Mental Health Web site](http://pediatrics.aappublications.org/content/125/Supplement_3/S109.full.pdf)
- **AAP Policy Portal** (features clinical guidelines, technical reports, policy statements, and more): [http://aappolicy.aappublications.org/index.dtl](http://aappolicy.aappublications.org/index.dtl)

**Element A: If our practice selects well-child care as an “important condition,” may we select one specific age group on which to base documentation examples?**

Yes, this is an acceptable approach.

**Element B: Is this the same set of patients from Element A?**

No. Elements A and B have different patient identification criteria, although some patients may fall into both categories.

Element B asks practices to document how they identify high-risk or complex patients (e.g., patients with a high level of resource use, frequent visits for urgent/emergent care/hospitalizations, multiple co-morbidities, multiple risk factors). Practices may have a registry of children and youths with special health care needs, or may use the Practice Management System to identify patients by ICD 9 codes utilized with high-risk patients (e.g., with asthma, allergic rhinitis, ADHD) in the entire patient panel. Identifying patients by ICD 9 codes would require the practice to narrow the list to patients who are high-risk or complex among all those with a broader condition.

**AAP Resources**

- **National Center for Medical Home Implementation Web site**, Clinical Care Information and Organization page provides patient registries templates: [http://www.medicalhomeinfo.org/how/clinical_care/#registries](http://www.medicalhomeinfo.org/how/clinical_care/#registries)
**Element C.3:** If our practice selects well-child care as an important condition, what is an example of acceptable documentation of a “written plan of care”?

For well-child patients, the plan of care may be the milestones that may occur before the next scheduled check-up, but may also include other items based on specific needs of a child or family. The important conditions identified in Element 3A are a means to identify a population of patients who will be selected for the medical record review. It is a mechanism of looking at the needs of individual patients, potentially with multiple and varied needs.

Examples of acceptable documentation include general parenting guidelines, as per Bright Futures, until the next check-up and meeting the outcomes described in the parenting guidelines. For Element 3C, documentation would be a report from the practice’s electronic system showing the frequency of performance across all of the practice’s patients or a review of a sample of patient records for documentation in the record. Findings are entered in NCQA’s Record Review Workbook (Excel spreadsheet).

For more guidance, refer to documentation section for Element 3C in the PCMH 2011 standards packet (pages 52–53) and to the instructions in the Workbook.

**AAP Resources**

- Interactive Periodicity Schedule (AAP Pediatric Care Online- Web resource): [https://www.pediatriccareonline.org/pco/ub/periodicity](https://www.pediatriccareonline.org/pco/ub/periodicity)
- Bright Futures for the Busy Clinical Practice, November 2009 (provides practical strategies for implementing the Bright Futures Guidelines for adolescents): [http://brightfutures.aap.org/pdfs/AHU1109.pdf](http://brightfutures.aap.org/pdfs/AHU1109.pdf)

**Element C.5:** What types of information should be included in a “clinical summary of the visit” for well-child care?

Regardless of the condition used to identify a patient as part of the file review, the clinical summary of the visit will reflect what occurred during the visit (e.g., measurements compared with developmental norms, findings, services provided and recommended follow-up).

**AAP Resources**

- The EQIPP: Bright Futures course helps pediatric health care providers create plans for improvement, and includes modules on performing age appropriate surveillance and screening and providing anticipatory guidance and follow-up care at every health supervision visit: [http://www.eqipp.org/](http://www.eqipp.org/)
- CDC Growth Charts for Children Aged 0-59 Months in the United States: [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w)
- AAP Interactive Periodicity Schedule: [https://www.pediatriccareonline.org/pco/ub/periodicity](https://www.pediatriccareonline.org/pco/ub/periodicity)
- BMI Calculator and Table: [http://www.aap.org/obesity/clinical_resources.html?technology=0](http://www.aap.org/obesity/clinical_resources.html?technology=0)
- Healthy Active Living Prescription Pads (these pads promote healthy eating and physical activity with patients; they are designed to be filled out by a provider along with the active involvement of the child and their parent/guardian): [http://brightfutures.aap.org/clinical_practice.html](http://brightfutures.aap.org/clinical_practice.html)
**Element D.3: Are excerpts from medical records indicating that medications and side effects were reviewed with the family acceptable documentation, or is a specific medication handout necessary?**

Excerpts from medical records outlining that medications and side effects were reviewed with the patient/family suffice.

3C, 3D and 4A require practices to review documentation in 48 patient medical records using the NCQA selection method and to enter the results in NCQA’s Record Review Workbook. NCQA does not require additional documentation.

**Element D.3: Does supplying information on all new prescriptions merely duplicate information provided by a pharmacy?**

Practices have a responsibility to ensure that patients/families understand why medication was prescribed and the medication’s benefits to the patient. Parents might not review prescription information provided by a pharmacy, and information might not be tailored to the needs of the child, the parents or the household.

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**PCMH 4: Provide Self-Care Support and Community Resources**

**Element A: If our practice uses well-child care as an important condition, what types of information are acceptable to document “self management”?**

Practices should provide self-management support specific to the needs of the individual (across conditions), regardless of the condition. Information provided to patients/families as part of anticipatory guidance during well-child checks (e.g., injury-prevention guidance, nutrition, sleep strategies) suffice.

**AAP Resources**

- National Center for Medical Home Implementation Web site, Care Partnership Support page links to self-management resources. The link is [http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#self](http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#self)

**Element A: If our practice uses an acute condition (e.g., pharyngitis, otitis media) as an important condition, what types of information are acceptable to document self management?**

Practices should provide self-management support specific to the needs of the individual (across conditions). Information provided to parents about home management of acute conditions and when to seek additional medical attention suffice.

**AAP Resources**

- AAP Consumer Education Brochures (e.g., Common Childhood Infections, Acute Ear Infections and Your Child, etc.)
- HealthyChildren.org, AAP’s consumer Web site, contains information on a variety of child health conditions and guidance for families: [http://www.healthychildren.org/english/health-issues/Pages/default.aspx](http://www.healthychildren.org/english/health-issues/Pages/default.aspx)
Element A.4.5.6: These factors require practices to support patient/family self-management. How can self-management support apply to well-child care?

For factor 4, practices should document the ability of parents to manage the mental, emotional, social and physical growth and development of the child.

For Factor 5, self-management tools may be a tracking sheet for items such as nutrition, physical activity and safety.

For Factor 6, counseling associated with well-child care may include physical activity or safety limits, unhealthy foods or foods that might contribute to allergies or child access to electronic entertainment.

AAP Resources

- Healthy Active Living Prescription Pads (these pads promote healthy eating and physical activity with patients; they are designed to be filled out by a provider along with the active involvement of the child and their parent/guardian): http://brightfutures.aap.org/clinical_practice.html
- Family Resources Portal on the AAP Prevention and Treatment of Childhood Overweight and Obesity Web site provides information on what families can do to provide a healthy home environment, as well as how families can partner with providers to prevent unhealthy child behaviors: http://www.aap.org/obesity/families.html?technology=1
- The AAP and Alliance for a Healthier Generation have partnered with the The Very Hungry Caterpillar by Eric Carle to help families learn about healthy eating habits; resources are available on the consumer Healthy Children.org Web site: (http://www.healthychildren.org/english/healthy-living/nutrition/the-very-hungry-caterpillar/Pages/default.aspx)

Element B.1: Must the resource be specifically related to the selected important conditions? Would a lactation consultant and other breastfeeding support services qualify?

Yes. Resources in 4B are not specific to patients with important conditions (such as those chosen in Element 3A), but are a limited number (five) of resource categories specific to the needs of the patients/families in a practice. Examples of resources include information/classes on breastfeeding, child care guidance, parenting skills, immunization information and so on.

Element B.1: Most of our families don’t need community resources. What should our practice report?

Choose the five key resource service areas relevant to your practice population and develop a list of resources for each of these service areas that you can provide. Your resource list might not necessarily include the examples listed in the PCMH 2011 standards and guidelines.

Beyond the traditional primary care essential for all children, families in your practice could benefit from other community-based services, such as fire prevention services, car seat installation, poison prevention services, playgroups and recreational programs.

AAP Resources

- Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition contains a Community Resources Chapter that includes a checklist for practices to structure an approach in identifying community resources that may enhance a practice’s ability to serve all patients and families: http://brightfutures.aap.org/index.html
PCMH 5: Track and Coordinate Care

*Elements 5A.B.C.:* Does our practice need an interoperable electronic system to receive credit for these elements?

No. an EHR is not needed for factors in these elements:

- Element 5A, factors 1–6
- Element 5B, factors 1–5
- Element 5C, factors 1–6

*Elements 5A.B.C.:* Does NCQA accept information that was scanned into a chart?

- **5A.7–10:** No. Retrieving the information and scanning the results into the chart does not meet the intent of 5A.7–10. Practices are asked to order and retrieve lab and imaging electronically. The one exception is an actual image (*not* results), which may be scanned into the chart.
- **5B.6 and 7:** No. Scanning is not acceptable. Documentation for these factors requires the practice to electronically exchange or provide information to clinicians external to the practice.
- **5C.7 and 8:** No. Scanning is not acceptable. Documentation for these factors requires the practice to electronically exchange or provide information to other facilities.

*Element A.10:* Must actual radiology images be stored in the patient’s medical record, or only in the report outlining results?

Practices are not required to have the capability for retrieving and storing radiology images. The report text is sufficient.

PCMH 6: Measure and Improve Performance

*Element B:* How often must our practice survey patients to meet this standard?

NCQA does not specify survey frequency. An example of a survey conducted within the past 12 months is acceptable documentation.

AAP Resources

- Measuring Medical Homes monograph ([http://www.medicalhomeinfo.org/downloads/pdfs/MonographFINAL3.29.10.pdf](http://www.medicalhomeinfo.org/downloads/pdfs/MonographFINAL3.29.10.pdf)) includes several patient surveys including:
  - Family-Centered Care Self-Assessment Tool: [https://org2.democracyinaction.org/o/6739/images/fcca_FamilyTool.pdf](https://org2.democracyinaction.org/o/6739/images/fcca_FamilyTool.pdf)
Element B: Does NCQA specify a survey that practices must use?

- Factor 1 identifies the question categories that must be included in the survey (i.e., access, communication, coordination and whole-person care/self-management support), but it does not require the use of a specific survey.
- Factor 2 requires use of the PCMH CAHPS Clinician Group survey, but this requirement does not take effect until six months after the PCMH CAHPS-CG Survey Tool is available (early 2012). Until that time, practices receive an automatic “yes” score for factor 2.

Element C.4: May parent members of our practice’s advisory council participate by telephone, as opposed to in-person meetings?

Yes. Documentation requirements include a written process and examples of meeting the process for involving patients/families in quality improvement teams or on practice advisory councils (e.g., meeting notes, agenda).

AAP Resources
- National Center for Medical Home Implementation Web site (resources on family advisory groups). The link is: http://www.medicalhomeinfo.org/how/care_partnership_support.aspx#groups
- Building Your Medical Home Toolkit (Quality Improvement Basics and associated teamwork pages include information on building teams and including families, along with meeting minutes and agenda templates). The link is www.pediatricmedhome.org.

For more information about NCQA’S PCMH 2011 Recognition Program, e-mail pcmh@ncqa.org or call 888-275-7585, M–F, 8:30 a.m.–5:00 p.m. ET.