Patient-Centered Medical Home (PCMH) 2014

Part 1: Standards 1-3
Agenda Part 1
• Content of PCMH 2014 Standards and Guidelines
  – Standards 1 - 3
  – Documentation Examples*

Agenda Part 2
• Content of PCMH 2014 Standards and Guidelines
  – Standards 4 - 6
  – Documentation Examples*

*Examples in the presentation only illustrate the element intent. They are NOT definitive nor the only methods of documenting how the requirements may be met.
## PCMH 2014 Content and Scoring
(6 standards/27 elements)

<table>
<thead>
<tr>
<th>Standards</th>
<th>Points</th>
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<tbody>
<tr>
<td><strong>1: Enhance Access and Continuity</strong></td>
<td></td>
</tr>
<tr>
<td>A. *Patient-Centered Appointment Access</td>
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</tr>
<tr>
<td>B. 24/7 Access to Clinical Advice</td>
<td>3.5</td>
</tr>
<tr>
<td>C. Electronic Access</td>
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<thead>
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<th>Standards</th>
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<tr>
<td><strong>2: Team-Based Care</strong></td>
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<tr>
<td>A. Continuity</td>
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<tr>
<td>B. Medical Home Responsibilities</td>
<td>2.5</td>
</tr>
<tr>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
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</tr>
<tr>
<td>D. *The Practice Team</td>
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<tr>
<td><strong>3: Population Health Management</strong></td>
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<tr>
<td>A. Patient Information</td>
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<td>B. Clinical Data</td>
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<td>C. Comprehensive Health Assessment</td>
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<td>D. <em>Use Data for Population Management</em></td>
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<td>E. Implement Evidence-Based Decision-Support</td>
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<td><strong>4: Plan and Manage Care</strong></td>
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<tr>
<td>A. Identify Patients for Care Management</td>
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<tr>
<td>B. *Care Planning and Self-Care Support</td>
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<td>C. Medication Management</td>
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<tr>
<td>D. Use Electronic Prescribing</td>
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<td>E. Support Self-Care and Shared Decision-Making</td>
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<td><strong>5: Track and Coordinate Care</strong></td>
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<td>A. Test Tracking and Follow-Up</td>
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<td>B. *Referral Tracking and Follow-Up</td>
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<td>C. Coordinate Care Transitions</td>
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<td><strong>6: Measure and Improve Performance</strong></td>
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<td>A. Measure Clinical Quality Performance</td>
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<tr>
<td>B. Measure Resource Use and Care Coordination</td>
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<td>C. Measure Patient/Family Experience</td>
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<td>D. *Implement Continuous Quality Improvement</td>
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</tr>
<tr>
<td>E. Demonstrate Continuous Quality Improvement</td>
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<td>F. Report Performance</td>
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<td>G. Use Certified EHR Technology</td>
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<tr>
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### Scoring Levels
- **Level 1:** 35-59 points.
- **Level 2:** 60-84 points.
- **Level 3:** 85-100 points.

### Must Pass Elements
- A. *Patient-Centered Appointment Access
- B. *Care Planning and Self-Care Support
- D. Use Electronic Prescribing
- E. Support Self-Care and Shared Decision-Making
PC MH Eligibility & Survey Components
Eligible Applicants

- **Outpatient primary care practices** that meet the scoring criteria for Level 1, 2, or 3 as assessed against Patient-Centered Medical Home (PCMH) requirements

- **Practice defined:** a clinician or clinicians practicing together at a single geographic location
  - Includes nurse-led practices in states where state licensing designates Advanced Practice Registered Nurses (APRNs) as independent practitioners
  - Does not include urgent care clinics or clinics opened on a seasonal basis
PCMH Eligibility Basics

- Recognitions are conferred at geographic site level -- one Recognition per address, one address per survey

- MDs, DOs, PAs, and APRNs practicing at site with their own or shared panel of patients are listed with Recognition

- Clinicians should be listed at each site where they routinely see a panel of their patients
  - Clinicians can be listed at any number of sites
  - Site clinician count determines program fee
  - Non-primary care clinicians should not be included
PCMH Clinician Eligibility

- At least **75% of each clinician’s patients** come for:
  - First contact for care
  - Continuous care
  - Comprehensive primary care services

- **Clinicians may be selected** as personal PCPs

- **All eligible clinicians at a site must apply together**

- **Physicians in training (residents) should not be listed**

- **Practice may add or remove clinicians during the Recognition period**
Must Pass Elements

Rationale for Must Pass Elements

• Identifies critical concepts of PCMH
• Helps focus Level 1 practices on most important aspects of PCMH
• Guides practices in PCMH evolution and continuous quality improvement
• Standardizes “Recognition”

Must Pass Elements

• 1A: Patient Centered Appointment Access
• 2D: The Practice Team
• 3D: Use of Data for Population Management
• 4B: Care Planning and Self-Care Support
• 5B: Referral Tracking and Follow-Up
• 6D: Implement Continuous Quality Improvement
Documentation Types

1. **Documented process** Written procedures, protocols, processes for staff, workflow forms (not explanations); must include practice name and date of implementation.

2. **Reports** Aggregated data showing evidence

3. **Records or files** Patient files or registry entries documenting action taken; data from medical records for care management.

4. **Materials** Information for patients or clinicians, e.g. clinical guidelines, self-management and educational resources

**NOTE:** Screen shots or electronic “copy” may be used as examples (EHR capability), materials (Web site resources), reports (logs) or records (advice documentation)
PCMH 1: Patient-Centered Access

**Intent of Standard**
The practice provides access to team-based care for both routine and urgent needs of patients/families/care-givers at all times

- Patient-centered appointment access
- 24/7 Access to clinical advice
- Electronic access

**Meaningful Use Alignment**
- Patients receive electronic:
  - On-line access to their health information
  - Clinical summaries of office visits
  - Secure messages from the practice
PCMH 1: Patient-Centered Access

10 Points

Elements

• PCMH 1A: Patient-Centered Appointment Access

**MUST PASS**

• PCMH 1B: 24/7 Access to Clinical Advice
• PCMH 1C: Electronic Access
PCMH 1A: Patient-Centered Access

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

1. Providing routine and urgent same-day appointments – **CRITICAL FACTOR**
2. Providing routine and urgent-care appointments outside regular business hours
3. Providing alternative types of clinical encounters
4. Availability of appointments
5. Monitoring no-show rates
6. Acting on identified opportunities to improve access

NOTE: Critical Factors in a Must Pass element are essential for Recognition
PCMH 1A: Scoring and Documentation

MUST PASS

4.5 Points

Scoring

• 5-6 factors (including Factor 1) = 100%
• 3-4 factors (including Factor 1) = 75%
• 2 factors (including Factor 1) = 50%
• 1 factor (including Factor 1) = 25%
• 0 factors = 0%

Must meet 2 factors (including factor 1) to pass this Must-Pass Element

Documentation

• F1-6: Documented process, definition of appointment types and
• F1: Report(s) with at least 5 days of data showing availability/use of same-day appointments for both routine and urgent care (cont)
F2: Materials communicating extended hours or report showing after-hours availability, process to arrange after-hours access not required if practice has regular extended hours.

F3: Report with frequency of scheduled alternative encounter types in recent 30-calendar-day period.

F4: Report showing appointment wait times compared to practice defined standards including policy for how practice monitors appointment availability with at least 5 days of data.

F5: Report showing rate of no shows from a recent-30-calendar day period. (Patients seen/Scheduled visits).

F6: Documented process indicating the method a practices uses to select, analyze and update its approach to creating greater access to appointments and a report showing practice has evaluated access data and implemented QI Plan to create greater access.
PCMH 1A, Factor 1: Example Same-Day Scheduling Policy

ABCD Medical Associates
Effective June 6, 2013

Personal Clinicians:
For all routine office visits (check-ups, follow-ups) and physicals, patients are to be scheduled with their personal clinician (which-ever provider they see on a regular basis) to keep continuity of care.

Same-Day Appointments:
Practices as an “Advanced Access” practice. Any patient that needs to be seen on a day the office is open (Monday – Saturday) will be able to be seen that day with the available clinician. Not all clinicians will have opening everyday due to their community schedules, but there will a clinician available to see a patient when they call.

Procedures and Exams:
When scheduling a patient for an annual physical, please make sure that they have the lab work done one week prior to visit. This will ensure that the results are in-house for the doctor to review at time of service.

When a patient is scheduling an office visit, please make sure to note and procedures or exams that need to be done (i.e. hearing test, EKG, skin tag removal…).
PCMH 1A, Factor 2: Routine & Urgent Care Outside Regular Hours

From Practice Brochure:

- Accessible Services:
- We have regular extended hours beyond normal 9-5
- We have a physician on call for emergency after hours
- We strive to achieve excellent communication.

Office Hours
Telephone Advice Hour
Monday - Saturday 7:30 AM - 8:30 AM
Patient Care Hours
Monday - Thursday: 8:30 AM - 7:30 PM
Friday 8:30 AM - 5 PM
Saturday 8:30 AM - 12:00 PM
The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

1. Continuity of medical record information for care and advice when the office is closed

2. Providing timely clinical advice by telephone - **CRITICAL FACTOR**

3. Providing timely clinical advice using a secure, interactive electronic system (NA if the practice cannot communicate electronically with patients) NA responses require an explanation

4. Documenting clinical advice in patient records
PCMH 1B: Scoring and Documentation

3.5 Points

Scoring

• 4 factors = 100%
• 3 factors (including Factor 2) = 75%
• 2 factors (including Factor 2) = 50%
• 1 factor (or does not meet factor 2) = 25%
• 0 factors = 0%

Documentation

• F1-4: Documented process and
• F2&3: Report(s) showing response times during and after hours (7 calendar day report(s) minimum)
• F4: Three examples of clinical advice documented in record. One example when office open AND one example when office closed.
PCMH 1B, Factor 2: Example Response

Times to Calls

Shows:
✓ Call date/time
✓ Response date/time
✓ If time meets policy

Response times to meet standards for timely telephone response:
(A telephone call audit was conducted for our practice for two weeks. Below are the results. The encounter number refers to the unique tracking ID our EMR assigns. It has been provided instead of confidential patient information, for tracking purposes. policy for telephone response time is 24 hours.)

<table>
<thead>
<tr>
<th>Encounter Number</th>
<th>Date we received phone request</th>
<th>Time of request</th>
<th>Date we responded to patient</th>
<th>Time of response</th>
<th>Elapsed Time</th>
<th>Response time meets policies?</th>
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<tbody>
<tr>
<td>3/20/09</td>
<td>11:26</td>
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<td>3/20/09</td>
<td>17:02</td>
<td>6 hours</td>
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<td>3/19/09</td>
<td>13:10</td>
<td>2 hours</td>
<td>yes</td>
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<td>3/18/09</td>
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<td>3/20/09</td>
<td>17:19</td>
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<td>yes</td>
</tr>
<tr>
<td>3/17/09</td>
<td>15:02</td>
<td></td>
<td>3/18/09</td>
<td>9:31</td>
<td>18 hours</td>
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<td>3/17/09</td>
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<td>10:00</td>
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<td>yes</td>
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<tr>
<td>3/19/09</td>
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<td>3/20/09</td>
<td>9:09</td>
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<td>16:19</td>
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<td>3/19/09</td>
<td>11:32</td>
<td>0.25 hours</td>
<td>Yes</td>
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PCMH 1C: Electronic Access

Practice provides through a secure electronic system:

1. > 50% of patients have online access to their health information within 4 business days of information being available to the practice*
2. >5% of patients view, and are provided the capability to download, their health information or transmit their health information to a third party *
3. Clinical summaries provided for > 50% of office visits within 1 business day *
4. Secure message sent by > 5% of patients*
5. Patients have two-way communication with the practice
6. Patients may request for appointments, prescription refills, referrals and test results *

* Stage 2 Meaningful Use Requirements
PCMH 1C: Scoring and Documentation

2 Points

Scoring

• 5-6 factors = 100%
• 3-4 factors = 75%
• 2 factors = 50%
• 1 factor = 25%
• 0 factors = 0%

Documentation

• F1-4: Reports based on numerator and denominator with at least 3 months of recent data
• F5 & 6: Screen shots showing the capability of the practice’s web site or portal including URL.
More than 50% of patients have online access to their health information within four business days of when the information available to the practice. (Stage 2 MU)

<table>
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<tr>
<th>Practice/Location</th>
<th>Denominator</th>
<th>Numerator</th>
<th>%</th>
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<tr>
<td>750</td>
<td>377</td>
<td>50</td>
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<tr>
<td>647</td>
<td>565</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>886</td>
<td>811</td>
<td>92</td>
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Reports need to be at the practice site level and include data for all primary care providers at the site. Data should be aggregated.
PCMH 2: Team-Based Care
PCMH 2: Team-Based Care

**Intent of Standard**
The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.
PCMH 2: Team-Based Care

12 Points

Elements

- **Element A:** Continuity
- **Element B:** Medical Home Responsibilities
- **Element C:** CLAS
- **Element D:** The Practice Team

**Must-Pass**
PCMH 2A: Continuity

The practice provides continuity of care for patients/families by:

1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.
2. Monitoring the percentage of patient visits with selected clinician or team.
3. Having a process to orient patients new to the practice.
4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.
PC MH 2A: Scoring

3.0 Points

Scoring

- 3-4 factors = 100%
- No scoring option = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%
PCMH 2A: Documentation

**Documentation**

- F1: Documented process for staff and materials for patients.
- F2: Report based on 5 days of data.
- F3: Documented process for staff to orient new patients.
- F4: For the following:
  - Pediatric practices - Example of a written transition care plan
  - Internal medicine and family medicine practices – documented process and materials for adolescent patients on importance of preventive, acute, chronic care.
PCMH 2A, Factor 2: Example of monitoring the percentage of patient visits

% of patient visits with preferred provider
PCMH 2B: Medical Home Responsibilities

The practice has a process for informing patients/families about role of the medical home and gives patients/families materials that contain the following information:

1. The practice is responsible for coordinating patient care across multiple settings.
2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.
3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.
PCMH 2B: Medical Home Responsibilities (cont.)

4. The care team provides access to evidence-based care, patient/family education and self-management support.

5. The scope of services available within the practice including how behavioral health needs are addressed.

6. The practice provides equal access to all of their patients regardless of source of payment.

7. The practice gives uninsured patients information about obtaining coverage.

8. Instructions on transferring records to the practice, including a point of contact at the practice.
PCMH 2B: Scoring and Documentation

2.5 Points

Scoring

• 7-8 factors = **100%**
• 5-6 factors = **75%**
• 3-4 factors = **50%**
• 1-2 factor = **25%**
• 0 factors = **0%**

Documentation

• F1-8: Documented process for providing information to patients and
• F1-8: Patient materials
PCMH 2C: Culturally and Linguistically Appropriate Services (CLAS)

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

1. Assessing the diversity of its population.
2. Assessing the language needs of its population.
3. Providing interpretation or bilingual services to meet the language needs of its population.
4. Providing printed materials in the languages of its population.
PC MH 2C: Scoring and Documentation

2.5 Points

Scoring

- 4 factors = 100%
- 3 factors = 75%
- 2 factors = 50%
- 1 factor = 25%
- 0 factors = 0%

Documentation

- F1 and 2: Report showing the practices assessment of racial, ethnic or other cultural diversity features and language composition of its patient population
- F3: Documented process for providing bilingual services
- F4: Patient materials
PCMH 2C, Factor 2: Assessing the Language Needs of the Population

<table>
<thead>
<tr>
<th>Language</th>
<th># of Patients</th>
<th>% of Patients</th>
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<tbody>
<tr>
<td>English</td>
<td>2191</td>
<td>79.30%</td>
</tr>
<tr>
<td>Spanish</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Russian</td>
<td>2</td>
<td>0.07%</td>
</tr>
<tr>
<td>Other</td>
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<td>0.04%</td>
</tr>
<tr>
<td>All other</td>
<td>0</td>
<td>0.00%</td>
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<tr>
<td>Blank field</td>
<td>573</td>
<td>20.74%</td>
</tr>
<tr>
<td>Total</td>
<td>2763</td>
<td></td>
</tr>
</tbody>
</table>

This is based on unique pts seen between 08/07/13 - 10/08/13. This sampling indicates that most of our patients speak English. We utilize staff that speak Spanish and also have available language line for any other languages that might be needed.
PCMH 2D: The Practice Team

The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members.
2. Identifying the team structure and the staff who lead and sustain team based care.
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR)
4. Using standing orders for services.
5. Training and assigning members of the care team to coordinate care for individual patients.

NOTE: Critical Factors in a Must Pass element are essential for Recognition
6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.

7. Training and assigning members of the care team to manage the patient population.

8. Holding scheduled team meetings to address practice functioning.

9. Involving care team staff in the practice’s performance evaluation and quality improvement activities.

10. Involving patients/families/caregivers in quality improvement activities or on the practice’s advisory council.
PC MH 2D: Scoring

**MUST-PASS**

**4 Points**

**Scoring**

- 10 factors = 100%
- 8-9 factors = 75%
- 5-7 factors = 50%
- 2-4 factor = 25%
- 0 factors = 0%
PCMH 2D: Documentation

• F1,2, 4-7 Staff position descriptions or responsibilities
• F3: Description of staff communication processes and sample of how pre-visit planning is conducted
• F4: Written standing orders
• F5-7: Description of training process, schedule, materials
• F6: Description of staff communication process and examples of training materials.
• F9: Description of staff role in practice improvement process or minutes demonstrating staff involvement
• F8: Description of staff communication processes and sample
• F10: Process demonstrating how it involves patients/families in QI teams or advisory council
PCMH 3: Population Health Management
PCMH 3: Population Health Management

**Intent of Standard**
The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

**Meaningful Use Alignment**
- Practice has searchable electronic system:
  - Race/ethnicity/preferred language
  - Clinical information
- Practice uses clinical decision support and electronic system for patient reminders
**PC MH 3: Population Health Management**

**20 Points**

**Elements**

- **Element A:** Patient Information
- **Element B:** Clinical Data
- **Element C:** Comprehensive Health Assessment
- **Element D:** Use Data for Population Management
- **MUST-PASS**
  - **Element E:** Implement Evidence-Based Decision Support
The practice uses an electronic system to record patient information, including capturing information for factors 1-13 as structured (searchable) data for more than 80 percent of its patients:

1. Date of birth.
2. Sex.
3. Race.
4. Ethnicity.
5. Preferred language.
6. Telephone numbers.

+ Stage 2 Core Meaningful Use Requirement
7. E-mail address.
8. Occupation (NA for pediatric practices).
10. Legal guardian/health care proxy.
11. Primary caregiver.
13. Health insurance information.
14. Name and contact information of other health care professionals involved in patient’s care.
PC MH 3A: Scoring

3 Points Scoring

• 10-14 factors = 100%
• 8-9 factors = 75%
• 5-7 factors = 50%
• 3-4 factor = 25%
• 0-2 factors = 0%

NOTE

• Factors 8 and 12 (NA for pediatric practices).
• Written explanation of an NA response is required.
PCMH 3A: Documentation

**Documentation**

- F1-13: Report with numerator and denominator with at least 3 months of recent data.
- F14: Documented process and three examples demonstrating process.
This certified system produced very graphic Meaningful Use reports that were used to show practice level (all providers) results for a 3 month reporting period.

Demographic percentage for 3 month duration: 1/1/14 - 4/1/14

Report covers all site providers.
PCMH 3B: Clinical Data

The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1-5 and 8-11 as structured (searchable) data:

1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.
2. Allergies, including medication allergies and adverse reactions* for more than 80 percent of patients.
3. Blood pressure, with the date of update for more than 80 percent of patients 3 years and older.+
4. Height/length for more than 80 percent of patients.+
5. Weight for more than 80 percent of patients.+
6. System calculates and displays BMI.+

*Stage 2 Core Meaningful Use Requirement
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).+

8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.+

9. List of prescription medications with date of updates for more than 80 percent of patients.

10. More than 20 percent of patients have family history recorded as structured data.++

11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.++

+ Stage 2 Core Meaningful Use Requirement
++ Stage 2 Menu Meaningful Use Requirement
PCMH 3B: Scoring and Documentation

4 Points

Scoring

• 9-11 factors = 100%
• 7-8 factors = 75%
• 5-6 factors = 50%
• 3-4 factor = 25%
• 0-2 factors = 0%

NOTE

• Factor 3 (NA for practices with no patients 3 years or older),
• Factor 7 (NA for adult practices), and Factor 8 (NA for practices who do not see patients 13 years).
• Written explanation is required for NA responses.

Documentation

• Factors 1-5, 8-11: Reports with a numerator and denominator
• Factors 6, 7: Screen shots demonstrating capability
PCMH 3C: Comprehensive Health Assessment

To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age- and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family.
5. Advance care planning (NA for pediatric practices).
PCMH 3C: Comprehensive Health Assessment (cont.)

7. Mental health/substance use history of patient and family.
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients).
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy.
PC MH 3C: Scoring

4 Points

Scoring

• 8-10 factors = 100%
• 6-7 factors = 75%
• 4-5 factors = 50%
• 2-3 factor = 25%
• 0-2 factors = 0%

NOTE

• Factor 5 (NA for pediatric practices)
• Factor 8 (NA for practices with no pediatric patients),
• Factor 9 (if practice does not see adolescent or adult patients).
• Written explanation for NA responses.
PCMH 3C: Documentation

Documentation

• F1-10: Report with numerator and denominator based on all unique patients in a recent three month period indicating how many patients were assessed for each factor.

OR

• F1-10: Review of patient records selected for the record review required in elements 4B and 4C, documenting presence or absence of information in Record Review Workbook.

NOTE: Report or record review must show more than 50 percent for a factor for the practice to respond “yes” to factor in survey tool.

• F8,9: Completed form (de-identified) demonstrating use of standardized tool.
### Preventive Care

- **Tobacco use**
- **Advised to quit**
- **Immunizations**
- **Screenings**
- **Condition-specific**

### Example Screening and Intervention

#### Preventive Care

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Status</th>
<th>Date (blank = today)</th>
<th>Record</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use</td>
<td>quit</td>
<td></td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Pneumovax</td>
<td></td>
<td></td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Flu shot</td>
<td></td>
<td></td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Colon CA Screen</td>
<td></td>
<td></td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td>Record</td>
<td></td>
</tr>
<tr>
<td>Pap</td>
<td></td>
<td></td>
<td>Record</td>
<td></td>
</tr>
</tbody>
</table>

#### Diabetes

- Not Applicable

#### CHF

- Not Applicable

#### CAD

- Not Applicable

#### Asthma

- Asthma Type: Persistent

#### Depression

- Not Applicable
PCMH 3D: Use Data for Population Management

At least annually practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidenced-based guidelines including:

1. At least two different preventive care services.+
2. At least two different immunizations.+
3. At least three different chronic or acute care services.+
4. Patients not recently seen by the practice.
5. Medication monitoring or alert.

+ Stage 2 Core Meaningful Use Requirement
PC MH 3D: Scoring

**MUST-PASS**

**5 Points**

**Scoring**

- 4-5 factors = **100%**
- 3 factors = **75%**
- 2 factors = **50%**
- 1 factor = **25%**
- 0 factors = **0%**
PCMH 3D: Documentation

Documentation

- F1-5:
  1) **Reports or lists** of patients needing services generated within the past 12 months (Health plan data okay if 75% of patient population)

  **AND**

  2) **Materials** showing how patients were notified for each service (e.g., template letter, phone call script, screen shot of e-notice).

- Practice must perform these functions at least **annually**.
PC MH 3E: Implement Evidence-Based Decision Support

The practice implements clinical decision support+ (e.g., point of care reminders) following evidence-based guidelines for:

1. A mental health or substance use disorder. (CRITICAL FACTOR)
2. A chronic medical condition.
3. An acute condition.
4. A condition related to unhealthy behaviors.
5. Well child or adult care.
6. Overuse/appropriateness issues.
PCMH 3E: Scoring and Documentation

4 Points

Scoring
• 5-6 factors (including factor 1) = 100%
• 4 factors (including factor 1) = 75%
• 3 factors = 50%
• 1-2 factors = 25%
• 0 factors = 0%

Documentation
• Factors 1-6: Provide
  ✓ Conditions identified by the practice for each factor and
  ✓ Source of guidelines and
  ✓ Examples of guideline implementation
NCQA Resources Available

Free training each month [http://www.ncqa.org/rptraining.aspx](http://www.ncqa.org/rptraining.aspx)

- **Getting On Board**
  - Includes How to Submit as a Multi-site

- **Standards (2-part program)**

- **Software Training**
  - Using the ISS System
  - The Online Application
NCQA Contact Information

Visit NCQA Web Site at [www.ncqa.org](http://www.ncqa.org) to:
- Follow the Start-to-Finish Pathway
- View Frequently Asked Questions
- View Recognition Programs Training Schedule

Contact NCQA Customer Support at 1-888-275-7585 M-F, 8:30 a.m. - 5:00 p.m. ET to:
- Acquire standards documents, application account, survey tools
- Questions about your user ID, password, access

For questions about interpretation of standards or elements to [submit a question to PCS](http://www.ncqa.org) (Policy/Program Clarification Support)
Questions?