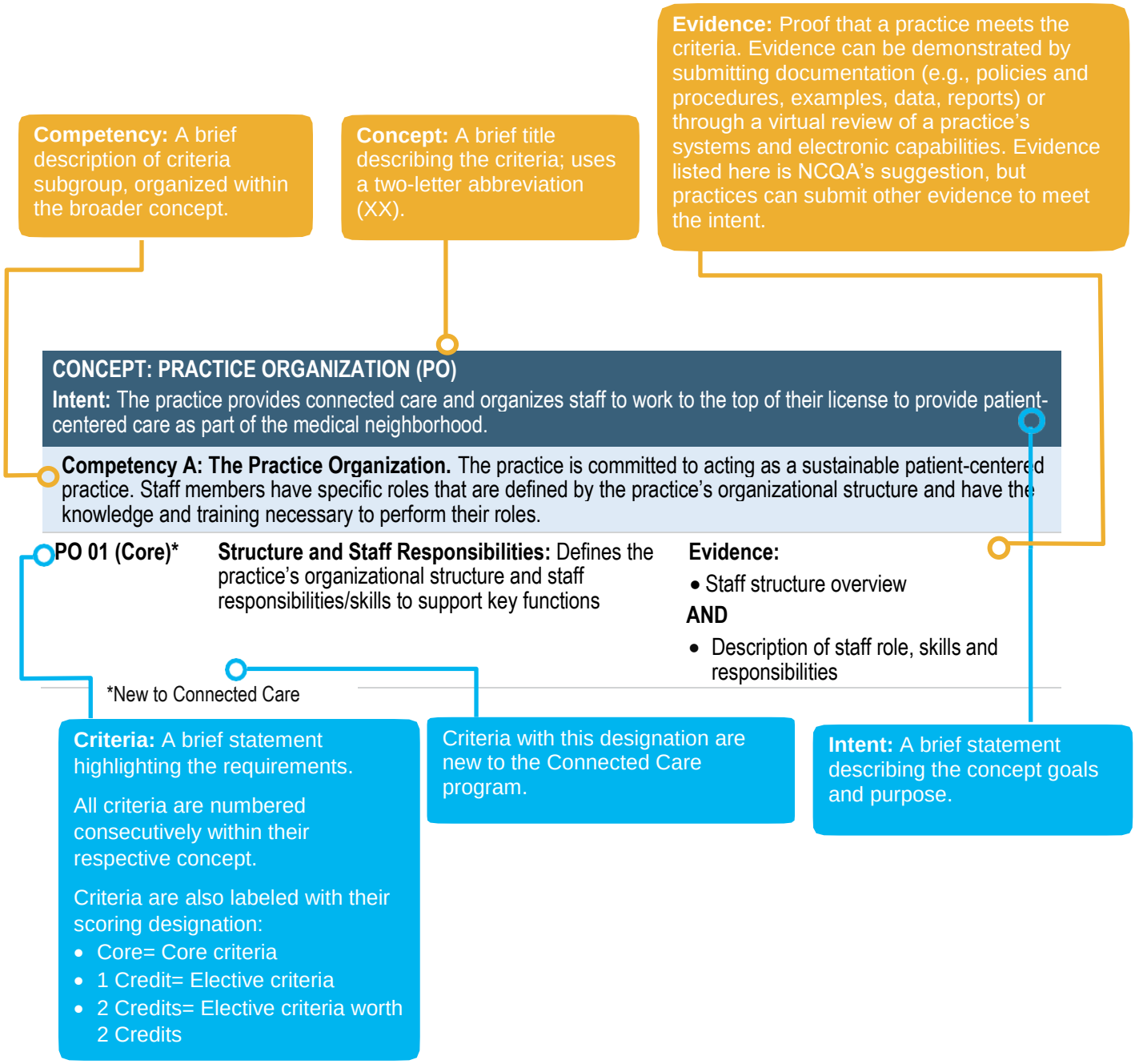
How to Read the New Standards:

The Patient-Centered Connected Care™ Recommendations Table details the proposed requirements. The table on this page outlines the layout and information.



Obsolete After November 9, 2018

*** = New to Connected Care**

Patient-Centered Connected Care™ Recognition Recommendations Table

PRACTICE ORGANIZATION (PO) ***Intent:*** The practice provides connected care and organizes staff to work to the top of their license to provide patient-centered care as part of the medical neighborhood.		
Competency A: The Practice Organization. The practice is committed to acting as a sustainable patient-centered practice. Staff members have specific roles that are defined by the practice's organizational structure and have the knowledge and training necessary to perform their roles.		
PO 01 (Core)*	**Structure and Staff Responsibilities:** Defines the practice's organizational structure and staff responsibilities/skills to support key functions.	**Evidence:** • Staff structure overview **AND** • Description of staff role, skills and responsibilities
PO 02 (Core)*	**Certified EHR System:** The practice uses a certified electronic health record technology (CEHRT) system.	**Evidence:** • CEHRT name
PO 03 (Core)*	**Staff Involvement in Quality Improvement:** Involves staff in the organization's performance evaluation and quality improvement activities.	**Evidence:** • Documented process **AND** • Evidence of implementation

Patient-Centered Connected Care™ Recognition Recommendations Table

Connecting and Coordinating with Primary Care (CP) ***Intent:*** The practice sets expectations for how it connects patients to primary care and shares visit information with primary care to deliver high-quality, coordinated care.		
Competency A: Connecting Patients With Primary Care. The eligible provider works with primary care clinicians to share information and connect patients with primary care clinicians if they do not have a usual source of primary care**.**		
CP 01 (Core)	**Documenting Primary Care Clinician:** Identifies and documents the primary care clinician in the medical record.	**Evidence:** • Documented process **AND** • Evidence of implementation ***or*** Report
CP 02 (Core)	**Communicates the Importance of Follow-Up With Primary Care:** Communicates to patients the importance of following up with their primary care clinician, when medically indicated.	**Evidence:** • Evidence of implementation
CP 03 (1 credit)	**Available Primary Care Clinicians:** Provides information on available primary care clinicians to patients without a primary care clinician.	**Evidence:** • Evidence of implementation
Competency B: Sharing Information with Primary Care. The practice provides timely, complete and relevant information to primary care providers to facilitate comprehensive care coordination.		
CP 04 (Core)	**Patient Information:** Documents and shares visit information with primary care: A. Procedures performed B. Diagnosis C. Diagnostic tests ordered D. Diagnostic test results E. Information on new prescriptions	**Evidence:** • Documented process **AND** • Report
CP 05 (Core)	**Shares Instructions Provided to Patient:** Shares with primary care the instructions given to the patient/family/caregiver, including recommendations for self-care support.	**Evidence:** • Documented process **AND** • Evidence of implementation ***or*** Report
CP 06 (Core)	**Shares Summary of Care Record:** A summary-of-care record with primary care clinician for more than 50 percent of visits, within one business day of the patient visit.	**Evidence:** • Application Worksheet **OR** • Record Review Worksheet
CP 07 (Core)	**Shares Pending Test Results:** More than 50 percent of test results that are not available before the patient leaves the provider's office, within one business day of receipt of the test results.	**Evidence:** • Application Worksheet

Obsolete After November 9, 2018

*** = New to Connected Care**

Connecting and Coordinating with Primary Care (CP) ***Intent:*** The practice sets expectations for how it connects patients to primary care and shares visit information with primary care to deliver high-quality, coordinated care.		
		OR • Record Review Worksheet
Competency C. Working with Primary Care. The eligible clinician collaborates with and coordinates care with primary care practices in the community.		
CP 08 (Core)	**Relationships with Primary Care:** Describes the relationships between eligible providers and primary care practices in the community, including type of relationship, goals and information exchange, including referral processes.	**Evidence:** • Documented process **AND** • Evidence of implementation ***OR*** Agreements

Patient-Centered Connected Care™ Recognition Recommendations Table

Understanding and Treating the Patient Population (UP) ***Intent:*** The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports individual and population needs and the provision of culturally and linguistically appropriate services.		
Competency A. Triaging and Determining Patient Needs. The practice determines patients' needs and whether its offices are the appropriate site of care.		
UP 01 (Core)	**Entity Information:** Has a process for informing patients/families/caregivers about its role and responsibilities and provides materials that contain the information.	**Evidence:** • Documented process **AND** • Evidence of implementation
UP 02 (Core)	**Medical History and Current Problem List:** Documents the medical history, current problem list, with current diagnoses, and records other patient details such as allergies, current blood pressure and smoking status.	**Evidence:** • Documented process **AND** • Evidence of implementation ***OR*** Report
UP 03 (Core)	**Assess Patients and Needs:** Conducts patient assessments to determine care needs.	**Evidence:** • Documented process **AND** • Evidence of implementation
UP 04 (Core)	**Contacting the Primary Care Clinician Prior to Treatment:** Determines if the primary care clinician needs to be contacted prior to treatment.	**Evidence:** • Evidence of implementation
UP 05 (Core)	**Determine Appropriateness of Care Setting:** Identifies patients needing services outside the scope of the provider's practice and redirect patients to a more appropriate care setting if necessary.	**Evidence:** • Documented process **AND** • Evidence of implementation
UP 06 (1 Credit)	**Determine Covered Services:** Assists patients to determine if services provided by the eligible provider or the services of the provider they are referred to, are covered by insurance.	**Evidence:** • Documented process **AND** • Evidence of implementation
Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.		
UP 07 (Core)	**Diversity:** Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population.	**Evidence:** • Report

Patient-Centered Connected Care™ Recognition Recommendations Table

Understanding and Treating the Patient Population (UP) ***Intent:*** The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports individual and population needs and the provision of culturally and linguistically appropriate services.		
UP 08 (Core)	**Language:** Assesses the language needs of its population.	**Evidence:** • Report
UP 09 (2 Credits) *	**Staff Cultural Competence and Health Literacy Skills:** Educates staff about cultural competence and health literacy and applies those skills when communicating with patients.	**Evidence:** • Evidence of implementation
Competency C: Collaborating with the Patient. The practice tailors its communication and care instructions to patient needs.		
UP 10 (Core)	**Shared Patient Decisions:** Collaborates with the patient/family/caregiver to make treatment decisions which include patient goals, potential barriers and self-care abilities.	**Evidence:** • Documented process **AND** Evidence of implementation
UP 11 (Core)	**Care Instructions:** Provides the patient/family/caregiver written care instructions, including recommendations for self-care.	**Evidence:** • Documented process **AND** Evidence of implementation
UP 12 (1 Credit)	**Self-Management Support:** Provides resources or refers patients/families/caregivers for assistance with self-management.	**Evidence:** • Documented process **AND** • Evidence of implementation
Competency D: Medication Management. The eligible provider reviews and documents all prescribed medications the patient is currently taking, addresses medication safety, barriers to adherence and educates patients about new prescriptions.		
UP 13 (Core)	**Document Medications:** Reviews and documents prescription and nonprescription medications for more than 80 percent of patients for patient safety.	**Evidence:** Report
UP 14 (1 Credit)	**New Prescription Education:** Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.	**Evidence:** • Report **AND** Evidence of implementation
UP 15 (2 Credits)	**Medication Responses and Barriers:** Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients and dates the	**Evidence:** • Report

Understanding and Treating the Patient Population (UP) ***Intent:*** The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports individual and population needs and the provision of culturally and linguistically appropriate services.		
	assessment.	**AND** Evidence of implementation
UP 16 (1 Credit)	**Controlled Substance Database Review:** Reviews a controlled substance database when prescribing relevant medications.	**Evidence:** Evidence of implementation
UP 17 (1 Credit) *	**Opioid Treatment Agreement:** For patients prescribed Schedule II opioid prescriptions, incorporates opioid treatment agreement into the patient medical record.	**Evidence:** Report
Competency E: Evidence-Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.		
UP 18 (Core)	**Clinical Decision Support:** Adopts at least three diagnostic or therapeutic clinical decision support at the point of care relevant to the population served.	**Evidence:** • Identifies conditions, source of guidelines **AND** Evidence of implementation **OR UP 19**
UP 19 (1 Credit)	**Additional Clinical Decision Support:** Adopts at least five diagnostic or therapeutic clinical decision support at the point of care relevant to the population served.	**Evidence:** • Identifies conditions, source of guidelines **AND** Evidence of implementation

Patient-Centered Connected Care™ Recognition Recommendations Table

Care Coordination and Care Transitions (CC) ***Intent:*** The practice systematically tracks tests, secondary referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with primary care and other providers in the medical neighborhood.		
Competency A: The practice effectively tracks and coordinates referrals to secondary specialists.		
CC 01 (Core)*	**Informing When Referring:** Informs the primary care clinician about referrals to secondary specialists.	**Evidence:** • Documented process **AND** • Evidence of implementation
CC 02 (1 credit)	**Consultation When Referring:** Discusses unanticipated referrals to secondary specialists with the primary care clinician and patient/family/caregiver.	**Evidence:** • Documented process **AND** • Evidence of implementation
CC 03 (1 Credit)	**Secondary Referral Management:** Systematically manages secondary referrals by: A. Giving the consultant or specialist the reason for the referral, the required timing and the type of referral. B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan. C. Tracking referrals until the consultant or specialist report is available, flagging and following up on overdue reports.	**Evidence:** • Documented process **AND** • Evidence of implementation
CC 04 (1 Credit) *	**Notification of Secondary Referral Results:** Ensures that the primary care clinician and the original referring clinician are notified of secondary referral results.	**Evidence:** • Documented process **AND** • Evidence of implementation
Competency B: Diagnostic Test Tracking and Follow-Up. The practice effectively tracks and manages diagnostic tests important for patient care and informs patients of the results.		
CC 05 (Core)	**Diagnostic Test Management:** Systematically manages diagnostic tests, including lab and imaging, by: A. Tracking diagnostic tests until results are available, flagging and following up on overdue results. B. Flagging abnormal diagnostic results, bringing them to the attention of the clinician. C. Notifying patients/families/caregivers about normal and abnormal diagnostic test results.	**Evidence:** • Documented process **AND** • Evidence of implementation
CC 06 (1 Credit)	**Provides Test Results:** Provides more than 50 percent of test results that were not available until after the visit to the patient/family/caregiver within one business day of receiving them.	**Evidence:** • Report

Obsolete After November 9, 2018

*** = New to Connected Care**

Care Coordination and Care Transitions (CC) ***Intent:*** The practice systematically tracks tests, secondary referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with primary care and other providers in the medical neighborhood.		
CC 07 (2 Credits) *	**Lab and Imaging Appropriateness**: Uses clinical protocols to determine when diagnostic tests are necessary.	**Evidence:** • Evidence of implementation

Obsolete After November 9, 2018

*** = New to Connected Care**

Patient-Centered Connected Care™ Recognition Recommendations Table

Performance Measurement and Quality Improvement (QI) ***Intent:*** The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities		
Competency A Measuring Performance. The practice uses measurement data to evaluates its performance and to identify opportunities for improvement.		
QI 01 (Core)	**Measure Performance:** The eligible provider monitors or receives data (must meet 3 categories, including A): A. At least three clinical measures related to the eligible provider's type. B. At least one measure related to care coordination. C. At least one measure affecting health care costs. D. Quantitative patient experience data. • Conducts a survey (using any instrument) to evaluate patient/family/caregiver experience across at least three dimensions, such as: – Access. – Communication. – Coordination. – Person-centered care, self-management support and comprehensiveness. E. Qualitative patient experience data. • Obtains patient/family/caregiver feedback through qualitative means.	**Evidence:** • Report
QI 02 (1 Credit) *	**Validated Patient Experience Survey Use:** Uses a standardized, validated patient-experience survey tool with available benchmarking data.	**Evidence:** • Report
Competency B: Set Goals and Improve Performance. The practice sets goals, prioritizes and implements improvement strategies then reevaluates its performance against those goals or benchmarks.		
QI 03 (Core)	**Goals and Actions to Improve:** Sets goals and acts to improve: (Demonstrate at least 2 options) A. A clinical measure related to the eligible provider's specialty. B. A measure related to care coordination. C. A measure effecting health care costs.	**Evidence:** • Report **OR** • Quality Improvement Worksheet
QI 04 (2 Credits)	**Improved Performance:** Achieves improved performance on at least two performance measures.	**Evidence:** • Report **OR** • Quality Improvement Worksheet

Patient-Centered Connected Care™ Recognition Recommendations Table

Performance Measurement and Quality Improvement (QI) ***Intent:*** The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities		
Competency C: Assess and Set Goals to Reduce Disparities. The practice seeks to reduce disparities in care for its vulnerable patients by measuring, goal setting, monitoring and acting to improve on stated goals**.**		
QI 05 (Max 2 Credits)	**Health Disparities Assessment:** Assesses health disparities using performance data stratified for vulnerable populations: A. Clinical quality (1 Credit). B. Patient experience (1 Credit).	**Evidence:** • Report **OR** • Quality Improvement Worksheet
QI 06 (2 Credits)	**Vulnerable Patient Feedback:** Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.	**Evidence:** • Report
QI 07 (2 Credits)	**Goals and Actions to Improve Disparities in Care/Services:** Sets goals and acts to improve performance on at least one measure of disparities in care or services.	**Evidence:** • Report **OR** • Quality Improvement Worksheet
QI 08 (2 Credits) *	**Improved Performance for Disparities in Care/Services:** Achieves improved performance on at least one measure of disparities in care or services.	**Evidence:** • Report **OR** • Quality Improvement Worksheet
Competency D: Reporting Performance. The practice shares performance data with staff, and may also share data with patients or publicly, for the measures and patient populations identified in Competency A.		
QI 09 (Core)	**Reporting Performance in the Practice:** Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	**Evidence:** • Documented Process **AND** • Evidence of implementation
QI 10 (1 Credit)	**Reporting Performance Publicly or With Patients:** Shares clinician-level or practice-level performance results publicly or with patients for measures it reports.	**Evidence:** • Documented Process **AND** • Evidence of implementation
QI 11 (2 Credits) *	**Patient/Family/Caregiver Involvement in Quality Improvement:** Involves the patient/ family/caregiver in quality improvement activities.	**Evidence:** • Documented Process **AND** • Evidence of implementation

Obsolete After November 9, 2018

*** = New to Connected Care**