

DRAFT

**Virtual Care Standards: Primary Care
and Urgent Care**

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Quality and Patient Safety

The organization has the quality improvement infrastructure to ensure the high quality and safe delivery of care through virtual modalities, and measures outcomes to improve the services it provides.

QPS 1: Program Structure (*Primary/Urgent Care*)

The organization's virtual care quality improvement program description includes the following information.

This is a core requirement.

Evidence Documented process

Guidance

- The virtual care services available to patients.
- The clinical guidelines used to inform delivery of virtual care.
- The defined patient population.
- Defined SMART (specific, measurable, attainable, relevant, time-limited) goals specific to the organization's virtual care program.
- An organizational chart with the care team or clinical operations staff roles and responsibilities.
- How the organization conducts quality assurance in how care is provided to patients, which may include having a continuous improvement process, measurement guidance, or governance.

The organization's program description may be integrated with how in-person care is delivered, but must specify how virtual care is delivered.

The organization defines how hybrid models are organized and staff allocated to virtual care, if applicable. The program description may be presented as a documented process, a work-flow or a standard operating procedure.

QPS 2: Person-Centered Care Plan (*Primary Care*)

The organization has a process to collect and document care plan goals using the person-centered outcomes approach.

This is a core requirement.

Evidence Documented process

Guidance

Person-centered outcomes are personalized, structured, measurable outcome goals identified by the patient and/or caregiver as what matters most to them. The person-centered outcomes approach helps organizations meet the dual aims of supporting goal-oriented care and facilitating structured, valid and reliable measurement of whether care is personalized and aligned with patient goals. The organization determines which patients would benefit most from person-centered goals. This approach is typically used with patients who have complex care needs.

The organization's process includes the following steps:

- Identify what matters most to the patient through a values discussion.
- Choose the top priority goal to work toward.

- Develop a SMART goal.

A free, online, self-led clinician training on how to identify and develop a person-centered outcome goal can be found on the NCQA Learning Management System here: https://education.ncqa.org/visitor_catalog_class/show/1275965.

QPS 3: Tracking Person-Centered Goals (*Primary Care*)

The organization has a process for tracking person-centered goals.

This is an elective requirement.

Evidence Documented process

Guidance The organization tracks person-centered goals identified in QPS 2. Organizations may use either a patient-reported outcome measure (PROM) or goal attainment scaling to track goal progress.

PROMs are standardized questionnaires that let patients to report on how they function or feel with respect to their health, quality of life, mental well-being or health care experience. The patient and clinician identify a PROM that best fits the goal, or is related to a barrier to the patient reaching the goal.

If the organization chooses to use PROMs to track goals, NCQA recommends that the organization have at least 8–10 PROMs for clinicians to choose from, for use with patients. If there are too few PROMs from which to choose, goals may be tailored to the available selection, rather than to the patient’s identified goal.

With goal attainment scaling, the clinician and patient use a continuum of five possible outcomes to define what it means to achieve the goal. The scale can then be used over time to track the goal and determine goal achievement.

Free, online, self-led trainings on tracking goals using a PROM or goal attainment scaling can be found on the NCQA Learning Management System.

Using Goal Attainment Scaling to Document and Track Health Outcome Goals: https://education.ncqa.org/visitor_catalog_class/show/1116724

QPS 4: Patient Consent (*Primary/Urgent Care*)

The organization requests patient consent to treatment through virtual modalities.

This is a core requirement.

Evidence Documented process

Guidance The organization’s process for requesting patient consent to virtual care includes documenting when consent is requested and if it is received through the patient’s health plan, if applicable.

Before a virtual visit or encounter, the organization confirms:

- That the patient is in a location conducive to receiving virtual care.
- The patient’s geographical location aligns with the treating provider’s licensure requirements.

QPS 5: Training (Primary/Urgent Care)

The organization provides staff training on relevant clinical and nonclinical topics.

This is a core requirement.

Evidence Documented process, Materials

Guidance The organization defines on-boarding requirements for the care team or clinical operations staff and practitioners who are new to virtual care, and for annual training of existing staff. The organization determines:

- The clinical and nonclinical topics required for training, including how training varies across provider types (i.e., physician, nurse practitioner, nurse).
 - At a minimum, training includes:
 - How care should be delivered through virtual modalities.
 - “Web-side manner,” defined as considerations for synchronous video professional display on camera, lighting, background and interpersonal communication skills for building trust in a virtual environment.¹
- Training type and frequency.
- Staff who require training.

The organization provides evidence of the training materials used and reports on the percentage of staff who completed training.

¹[To succeed with telehealth, know your “webside manner” | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org)

QPS 6: Health Assessment (Primary Care)

The organization performs an assessment to receive patient health history.

This is a core requirement.

Evidence Documented process, Report

Guidance The organization describes its process, and provides evidence, for performing patient assessments to receive patient health history during a virtual visit. The organization outlines its process for referring patients to in-person modalities to complete measurements (e.g., labs and other diagnostic imaging tests) the organization deems appropriate.

The organization’s process outlines:

- How (method), when (timing) and what information is collected during assessments.
- If tools or instruments are used.
- Frequency of updating assessments, if applicable.

QPS 7: Health Assessment (Urgent Care)

The organization performs a problem-focused health assessment.

This is a core requirement.

Evidence Documented process; Report

Guidance The organization describes its process, and provides evidence, for performing a problem-focused patient assessment, based on the reason for the patient's visit. The organization outlines its process for referring patients to in-person modalities to complete measurements (e.g., labs and other diagnostic imaging tests), as it deems appropriate. The organization determines the setting and frequency of performing and updating health assessments.

QPS 8: Medication Reconciliation (Primary/Urgent Care)

The organization completes a full medication reconciliation at every visit for at least 90% of patients.

This is a core requirement.

Evidence Report

Guidance The organization reviews all prescribed medications and supplements (if applicable) a patient is taking, and documents this in the medical record for at least 90% of patients. Clinical staff identify and address conflicts or potential discrepancies in medications.

Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. **Medication reconciliation** is the process of obtaining and maintaining an accurate list of all medications a patient is taking, to address potential conflicts (e.g., name, dosage, frequency, drug-drug interactions). Medication reconciliation is an important safety net during care transitions, because patients are more likely to be elderly, use multiple pharmacies, have multiple providers and have co-morbid conditions.

QPS 9: Prescribing Patterns (Primary/Urgent Care)

The organization tracks medication prescribing practices and performs analysis on prescribing patterns.

This is an elective requirement.

Evidence Documented process, Report

Guidance The organization has a process for tracking prescribed medications, and determines which medications to track. At a minimum, the organization tracks practitioner prescriptions of antibiotics, narcotics and steroids. The organization then tracks and analyzes trends or patterns in the practitioner's prescribing history. The organization provides evidence that it tracks medication prescribing practices and reports on its analysis of prescribing patterns.

QPS 10: Quality Measurement (Primary Care)

The organization selects three quality measures to evaluate the quality of primary care delivered through virtual modalities.

This is a core requirement.

Evidence Report

Guidance The organization chooses three of the following six clinical quality measures to report:

1. Blood Pressure Control.
2. Diabetes Control (HbA1c).
3. Closing the Referral Loop.
4. Detection in Depression Diagnosis and Management.
5. Immunization.
6. Prevention (e.g., Colorectal Cancer, Breast Cancer Screening).

Measures may be electronic clinical quality measures (eCQM) or HEDIS measures. Organizations that choose to report on eCQMs must leverage the measure information, specifications and data elements outlined in the Electronic Clinical Quality Improvement (eCQI) Resource Center.¹

Hybrid model of care

For the hybrid model of care, organizations only include patients who are attributed to its virtual panel, or who were seen in a virtual visit at least once during the measure reporting period.

¹<https://ecqi.healthit.gov/>

QPS 11: Quality Measurement (Urgent Care)

The organization selects three clinical quality measures to evaluate the quality of urgent care delivered through virtual modalities.

This is a core requirement.

Evidence Report

Guidance The organization reports on the following three clinical quality measures:

1. Appropriate Treatment for Upper Respiratory Infection (URI).
2. Appropriate Testing for Pharyngitis.
3. Closing the Referral Loop.

Measures may be electronic clinical quality measures (eCQM) or HEDIS measures. Organizations that choose to report on eCQMs must leverage the measure information, specifications and data elements outlined in the Electronic Clinical Quality Improvement (eCQI) Resource Center.¹

Measures include activities conducted during all telehealth visits, conducted through any virtual modality. Measure input activities should be exclusive to care delivered through virtual modalities.

¹<https://ecqi.healthit.gov/>

Care Coordination

The organization has a process for accounting for patients across the continuum of care delivery, to facilitate informed visits.

CC 1: Patient Intake Process (*Primary Care*)

The organization receives a patient's self-reported medical health history before a scheduled visit.

This is a core requirement.

Evidence Documented process; Materials

Guidance The organization receives as much information on a patient's medical health history before a visit. The organization describes its patient intake process, including how it receives information on new patients, and the frequency for updating the medical history of existing patients. The organization provides evidence demonstrating how it conducts a screening, assessment or questionnaire to receive patients' medical health history.

CC 2: Informed Visit (*Primary Care*)

The organization integrates the patient's medical health history before a scheduled visit.

This is an elective requirement.

Evidence Documented process, Evidence of implementation

Guidance The organization provides evidence demonstrating how its EHR system integrates a patient's medical health history prior to a visit. Integration may include a health information exchange or direct integration of patient medical health history from payers or providers. The organization demonstrates how its EHR system receives information from other EHR systems.

CC 3: Triage (*Primary/Urgent Care*)

The organization has a process for triaging patient visits.

This is a core requirement.

Evidence Documented process

Guidance The organization describes its process for using information gathered in CC 1 and CC 2 to triage patients for treatment based on clinical urgency. The organization's process states the method the organization uses for clinical decision support (i.e., algorithms, other methods).

CC 4: Appropriate Modality of Care (*Primary/Urgent Care*)

The organization has a process for determining that virtual care is appropriate for the patient.

This is a core requirement.

Evidence Documented process

Guidance Before and during the patient visit (whichever is deemed appropriate), the organization uses the information collected in CC 1–CC 3 to determine if virtual care is appropriate for a patient, with respect to the level of care needed and the organization’s capability.

The organization’s process specifies the types of practitioners appropriate for conditions treated through virtual modalities. Patients are treated by practitioners in the same or a similar specialty related to the condition requiring treatment.

If the organization determines that virtual modality is inappropriate, including in situations that require escalation to in-person care, it outlines its process for referring patients to care in the appropriate modality.

CC 5: Referral Process (*Primary/Urgent Care*)

The organization has a referral process.

This is a core requirement.

Evidence Documented process

Guidance The organization uses the patient’s medical health history and clinical protocols to determine when a referral is necessary. At a minimum, the organization confirms that referrals are local to the patient’s community of residence and whether the referral is in the patient’s practitioner network.

The organization defines the time frames for referrals, and includes the following information in the referral request:

- The patient’s medical health history and other parameters necessary to facilitate care.
- What is expected from the referring provider, the required level of engagement and how to follow up (i.e., one-time consultation, co-management), if appropriate.
- The expectation that the specialist/ancillary provider will close the loop.

The organization communicates referral expectations to patients, including the contact information of the referring provider, and additional instructions or education, if applicable.

CC 6: Cultural Preferences (Primary/Urgent Care)

The organization considers patients' cultural preferences during referrals.

This is an elective requirement.

Evidence Documented process

Guidance The organization's referral process confirms that referrals align with a patient's cultural preferences, which may include considerations for language, sexual orientation, gender identity or other needs identified by the patient.

CC 7: Closed-Loop Referral Systems (Primary Care)

The organization has closed-loop referral systems, and follows up within a defined time frame.

This is a core requirement.

Evidence Documented process, Evidence of implementation

Guidance The organization has closed-loop referral systems to communicate relevant patient information from primary care to the referred specialist/ancillary provider. The organization's system defines the time frames for closing the loop with referrals made in CC 4. The organization follows up with the specialist/ancillary provider, or with patients, to confirm that a service was received.

CC 8: Closed-Loop Referral Systems to Primary Care (Urgent Care)

The organization has a closed-loop referral system to follow up with primary care practitioners within a defined time frame.

This is a core requirement.

Evidence Documented process

Guidance The organization has closed-loop referral systems so that all relevant patient information is communicated back to the patient's primary care provider. For continuity of care, the organization follows up with the specialist/ancillary provider, or with patients, to confirm that a service or order was completed.

CC 9: Referral to Primary Care Practitioner (Primary/Urgent Care)

The organization has a process for determining that patients have a primary care practitioner, and refers patients to a primary care practitioner if they do not have one.

This is a core requirement.

Evidence Documented process

Guidance The organization determines whether patients have a primary care practitioner, and

provides patients with resources to a practitioner if they do not have one. The organization:

- Provides a list of primary care practitioners in the patient's community of residence.
- Encourages patients to contact their insurance provider to verify coverage before choosing a practitioner.

If the patient does not have insurance, the organization connects the patient with local resources to assist them with low-cost options for primary care.

CC 10: Two-Way Communication (*Primary/Urgent Care*)

The organization has an electronic system that facilitates two-way communication between patients and practitioners in a defined time frame.

This is a core requirement.

Evidence Documented process, Report

Guidance The organization has an interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication, including asynchronous communication between the organization and patients/families/caregivers, as applicable to the patient.

The organization has a process for defining modes of communication based on clinical need and patient preference, including a time frame for communicating with patients and providers.

NCQA reviews a report summarizing the organization's expected response times, and how the organization monitors its performance against standards for timely response, both during and after virtual office hours.

CC 11: Technological Assistance (*Primary/Urgent Care*)

The organization has a process for providing technological assistance to individuals before and during appointments.

This is a core requirement.

Evidence Documented process

Guidance The organization has a process for performing the following activities before a patient appointment:

- Communicating technical requirements to the individual, with instructions for contacting virtual technical support, including a phone number.
- Providing requirements of the visit via email, text message, phone call or other method of communication.
- If applicable, providing patient advocates or caregivers with a link to access patient appointments.

The process includes how the organization provides live technical assistance during the appointment.

CC 12: Advanced Technological Assistance (Primary/Urgent Care)

The organization has a process for providing advanced technological assistance to individuals before appointments.

This is an elective requirement.

Evidence	Documented process
Guidance	<p>The organization has a process for performing the following activities before a patient appointment:</p> <ul style="list-style-type: none"> • Testing the individual's ability to connect to the virtual care platform. • Determining whether individuals with disabilities need additional support services to facilitate virtual visits.

CC 13: Health Education Materials (Primary/Urgent Care)

The organization provides health education materials to patients following a care interaction.

This is a core requirement.

Evidence	Documented process, Materials
Guidance	<p>The organization provides patient materials to supplement visits, including, but not limited to, educational materials related to diagnoses and other items discussed during the interaction, post-visit summaries and relevant follow-up instructions. Supplemental materials provided to virtual patients are the same as those provided to in-office patients.</p> <p>The organization provides evidence that materials are available after the appointment through a patient portal system, email or other form of virtual communication.</p>

CC 14: Translated Health Education Materials (Primary/Urgent Care)

The organization translates health education materials for patients following the care interaction.

This is an elective requirement.

Evidence	Documented process, Materials
Guidance	<p>The organization provides patient materials provided in CC 13 in at least one language other than the primary language used by the organization. The organization determines the language(s) that are most relevant based on the language(s) spoken by the population.</p> <p>The organization provides evidence that translated materials are made available after the appointment through a patient portal system, email or other form of virtual communication.</p>

CC 15: Evaluation of Supporting Materials (Primary/Urgent Care)

The organization evaluates the reading level of supporting materials provided to patients following the care interaction.

This is an elective requirement.

Evidence	Documented process, Materials, Report
Guidance	Supporting materials are at a 4th or 5th grade reading level. The organization has a process for evaluating whether materials meet the reading level, and determines which materials require evaluation. The organization provides evidence that it evaluates materials.

CC 16: Information for Appeals (Primary Care)

The organization provides clinical information in response to appeals of denials based on medical necessity or treatment guidelines.

This is an elective requirement.

Evidence	Documented process
Guidance	<p>The organization has a process for providing clinical information in response to appeals of denials based on medical necessity or treatment guidelines. The relevance of clinical information is considered in terms of the criteria used to make the denial decision (i.e., the clinical information provided by the organization is related to the rationale stated in the denial notice).</p> <p>If the organization cannot provide the clinical information relevant to the denial, it documents its attempts to gather the information.</p>

Equitable Access

The organization uses patient data to assess for disparities and to focus quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities.

EA 1: Services Covered by Insurance (*Primary/Urgent Care*)

The organization has a process for informing patients which services are covered by insurance.

This is an elective requirement.

Evidence Documented process

Guidance The organization has a process for helping patients determine if services delivered during the virtual visit are covered by their insurance, and the amount of copay. The timing and scope of the information is based on the patient's needs. "Informing patients" may be through referral to additional resources or patient advocacy organizations that specialize in educating patients on insurance benefits.

If the organization does not contract with insurance, it outlines its process for informing patients of the cost of the virtual services and referrals to labs and imaging and diagnostic testing, if appropriate.

EA 2: Demographic Data Collection (*Primary Care*)

The organization directly collects data on the diversity of its population, including data on race, ethnicity, language, gender identity and sexual orientation.

This is a core requirement.

Evidence Documented process, Reports or materials

Guidance Although it is voluntary for patients to report these aspects of diversity, the organization must attempt to collect the information. The organization has a documented process for direct data collection, and demonstrates data collection through materials or reports.

Direct data collection is asking individuals for information (e.g., through enrollment or registration forms, surveys, data collection scripts, member or customer service calls, case management intake forms, health assessments). The organization's process for direct data collection includes, at a minimum:

- A description of the population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals if a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting).
- How (method of collection) and by whom (e.g., case worker, Member Services staff) data will be collected.
- Questions that will be used to collect data, including a script to guide staff who

collect or assess data verbally, when applicable.

The organization may collect data directly at points of interaction with patients and through multiple mechanisms, using as many channels as are available. The organization directly collects information on how patients identify in at least five areas that include:

A. Race/Ethnicity: The organization must be able to report race/ethnicity using OMB categories, including the response option of “Other.” While the OMB recommends a two-question format, asking for ethnicity before race, the organization may also use a combined format. In both cases, the National Academy of Medicine (NAM) recommends that respondents be instructed to select one or more categories that apply.¹ If the organization uses more detailed subcategories of race/ethnicity, it must have a consistent process to aggregate responses into OMB categories.

OMB two-question format

- Ethnicity
 - Hispanic or Latino.
 - Not Hispanic or Latino.
 - (Declined).
- Race (select one or more):
 - Black or African American.
 - Native Hawaiian or Other Pacific Islander.
 - White.
 - Asian.
 - American Indian or Alaska Native.
 - Some other race.
 - (Declined).
- OMB combined format (check all that apply):
 - American Indian or Alaska Native.
 - Asian.
 - Black or African American.
 - Hispanic or Latino.
 - Native Hawaiian or Other Pacific Islander.
 - White.
 - Other, please specify: _____.
 - (Declined).

Organizations may use another method to ask these questions if responses can be systematically aggregated to OMB categories.

B. Language: The organization may use the NAM recommendation to evaluate language needs, or may use another method of asking about language preference, if it describes the process. The NAM recommends the use of two questions to determine language needs:

- Spoken English Language Proficiency (Very well, Well, Not well, Not at all), with limited English proficiency defined as “Less than very well.”
- Spoken Language Preferred for Health Care, using locally relevant choices from a national standard list, plus a response option for “Other, please specify,” and including American Sign Language in the spoken language need list.

The NAM also recommends collecting preferred language for written materials, where possible, and including Braille when written language is elicited. The organization may use language needs information obtained directly from individuals to enable communication in the requested language (e.g., written information in a language other than English). The organization may also share language needs information with practitioners and providers, enabling them to provide language services more effectively. The organization must also disclose the possibility of the information being shared.

C. Gender identity: At a minimum, the organization describes its process for direct collection of gender identity data from adults 18 and older. Although not required, if the organization collects the data from individuals younger than 18, it describes the difference between its processes for collecting the data from adults and from individuals younger than 18. The organization uses USCDI² categories to collect gender identity data, which includes the following response options:

- Male.
- Female.
- Transgender male/trans man/female-to-male (FTM).
- Transgender female/trans woman/male-to-female (MTF).
- Genderqueer, neither exclusively male nor female.
- Additional gender category or other, please specify.
- Choose not to disclose.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was not provided (i.e., the information is unavailable), distinct from receiving the response option “Choose not to disclose” (i.e., the individual declines to share the information).
- A defined process for soliciting information from individuals when a response was requested but not provided.

E. Sexual orientation: At a minimum, the organization describes its process for direct collection of sexual orientation data from adults 18 and older. Although not required, if the organization collects sexual orientation data from individuals younger than 18, it describes the difference between its processes for collecting the data from adults and from individuals younger than 18. The organization uses the USCDI³ categories to collect sexual orientation data, which includes the following response options:

- Lesbian or gay or homosexual.
- Straight or heterosexual.
- Bisexual.
- Something else, please describe.
- Don’t know.
- Choose not to disclose.
- Additional options, as the organization deems appropriate.
- The ability to record when a response was requested but the individual has not yet provided a response (i.e., the information is unavailable), distinct from receiving a response option “Don’t know” (i.e., the individual does not know) or “Choose not to disclose” (i.e., the individual declines to share the information).

- A defined process for soliciting information from individuals when a response was requested but not provided.

¹<https://www.healthit.gov/isa/united-states-core-data-interopability-uscdi#uscdi-v4>

²<https://www.healthit.gov/isa/taxonomy/term/2736/uscdi-v2>

³<https://www.healthit.gov/isa/taxonomy/term/2741/uscdi-v2>

EA 3: Social Needs Data Collection (*Primary Care*)

The organization screens patients for four of the seven outlined social need categories.

This is a core requirement.

Evidence Documented process, reports or materials

Guidance **Social needs** are the nonclinical needs individuals identify as essential to their well-being. The organization screens the patient for four out of seven social needs:

1. Financial insecurity.
2. Food insecurity.
3. Housing stability.
4. Access to transportation.
5. Access to technology and internet connection. * (*Critical factor*)
6. Interpersonal safety.
7. Social connection.

Although it is voluntary for individuals to report social needs, the organization must attempt to collect this information. The organization may collect data directly at multiple points of interaction with individuals and through multiple mechanisms, using as many channels as are available.

The organization has a documented process for collecting data and demonstrates data collection through materials or reports. For each social need, the organization defines its method for assessing or collecting data directly and determining if an internally developed or external screening tool, vendor or platform was used.

Direct data collection is asking individuals for information (e.g., through enrollment or registration forms, surveys, data collection scripts, member or customer service calls, case management intake forms, health assessments). A direct data collection framework includes, at a minimum:

- A description of the population or subset of individuals from whom data will be collected.
- A defined process for soliciting information from individuals in the instance that a response was requested but not provided.
- When data will be collected.
- Where data will be collected (setting).
- How (method of collection) and by whom (e.g., case worker, Member Services staff) data will be collected.
- Questions that will be used to collect data, including a script to guide staff who collect or assess data verbally, when applicable.

The organization may receive, exchange or use data stored, collected or assessed by sources such as CMS, state or local agencies, community-based organizations, Federally Qualified Health Centers, health systems, hospitals, integrated delivery systems, provider networks, EHRs, HIEs and case management systems that have made a direct request for social needs information from individuals.

The organization determines the standardized screening tool to use for social needs. Widely accepted social needs assessment tools include, but are not limited to:

- The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool from the National Association for Community Health Centers.¹
- The Health Leads Model.²
- The Accountable Health Communities-Health-Related Social Needs Screening Tool created by the Centers for Medicare & Medicaid Services (CMS) to support the CMS Accountable Health Communities Model.³
- The EveryONE Project of the American Academy of Family Physicians.⁴
- Catalogs of social needs screening and assessment tools include:
 - Systematic Review of Social Risk Screening Tools by the Kaiser Permanente Washington Health Research Institute, in collaboration with the Social Interventions Research & Evaluation Network (SIREN).⁵
 - The Social Needs Screening Tool Comparison Table,⁶ compiled by SIREN, summarizes characteristics for several of the most widely used social health screening tools, including by intended population or setting, social health domains covered and number of questions about each domain.
- The Health Leads Screening Toolkit.⁷

¹<https://www.nachc.org/research-and-data/prapare>

²<https://healthleadsusa.org>

³<https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

⁴https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

⁵<https://sdh-tools-review.kpashingtonresearch.org/>

⁶<https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison>

⁷<https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/>

EA 4: Social Needs Referrals (*Primary Care*)

The organization follows up with patients to provide referrals for social needs services.

This is a core requirement.

Evidence Documented process, Reports or materials

Guidance After the organization collects data on social needs in EA 3, it refers patients to the appropriate resources, including community partnerships, community-based organizations, social service agencies, self-management resources or other tools that serve the identified social need. The organization's documented process includes that it obtains patient consent for a referral to confirm it is a priority for the patient.

EA 5: Use of Data to Improve Access (Primary Care)

The organization uses the data it collects on race, ethnicity, language, gender identity and sexual orientation to identify and implement one opportunity to improve access to virtual care.

This is an elective requirement.

Evidence Report, Implementation plan

Guidance The organization uses the data it collects on race, ethnicity, language, gender identity and sexual orientation to identify and implement at least one opportunity to improve access to virtual care.

If the organization has not implemented an opportunity to improve access, it may submit an implementation plan detailing planned actions.

EA 6: Use of Data to Assess Disparities (Primary Care)

The organization uses the data it collects on race, ethnicity, language, sexual orientation and gender identity to determine at least one disparity in clinical outcomes.

This is a core requirement.

Evidence Report, Implementation plan

Guidance The organization stratifies one or more clinical performance measures by using the collected data, focusing on subgroups most relevant to the demographics of the population served and that are feasible to measure, given the number of individuals in the groups.

The organization identifies a clinical performance measure, based on the types of clinical care it provides, that meets the following criteria:

- Addresses a relevant clinical outcome.
- Produces a quantifiable result.
- Is population based.
- Uses data and a method that is valid for the outcome being measured.

The organization identifies at least one disparity in the clinical performance measure chosen, and describes its process for identifying health care disparities in clinical performance measures.

EA 7: Use of Data to Improve Disparities (Primary Care)

The organization implements an intervention to reduce disparities, and measures the intervention's effectiveness.

This is a core requirement.

Evidence Report, Implementation plan

Guidance The organization uses the opportunity identified in EA 6 to implement at least one intervention to reduce disparities. The organization indicates its rationale for choosing a particular intervention. The organization evaluates the effectiveness of its intervention and outlines its evaluation process.

The organization may use direct data, indirect data, or a combination, for the evaluation, and may submit an implementation plan detailing its evaluation process, if it has not yet conducted one.

EA 8: Interpreter Services (Primary/Urgent Care)

The organization uses competent interpreter or bilingual services to communicate with individuals in a language other than English.

This is a core requirement.

Evidence Documented process, Reports or materials

Guidance The organization has a process for providing care in a patient's preferred language, based on language data collected. The organization provides competent interpreter or bilingual services for languages other than English spoken by 5% of the population, or by 1,000 individuals, whichever is less. A "competent interpreter" understands and speaks with enough fluency in both the source and target languages to convey intended meaning. The organization provides reports or materials as evidence that it uses competent interpreter or bilingual services to communicate with individuals who need language assistance.

The organization may provide interpreter services directly through professional interpreters or bilingual staff, or through contracts with language service providers, including electronic media (e.g., telephone language lines, video links, mobile applications) and other remote systems.

"Bilingual staff" speak both English and the patient's language, and can perform their responsibilities in either language.

- If the organization uses staff interpreters or bilingual staff, its process for assessing translators includes assessing their proficiency in the source and target languages, and interpretation training for staff who provide interpreter services.
- If the organization uses external interpreter services, its process for procuring interpreters includes assessing their competence.

EA 9: Staff Training (Primary/Urgent Care)

The organization trains its staff on cultural sensitivity, health literacy, reducing bias or promoting inclusion.

This is a core requirement.

Evidence Training materials, Evidence of implementation

Guidance At least annually, the organization:

- Provides ongoing training to all employees on culturally and linguistically appropriate practices, health literacy, reducing bias or promoting inclusion.
 - Training may be offered throughout the year, but must be completed by employees annually.
- Reports on the number or percentage of employees who have completed training.

Health literacy resources

- AHRQ Health Literacy Universal Precautions Toolkit:
<https://www.ahrq.gov/health-literacy/quality-resources/tools/literacy-toolkit/index.html>

EA 10: Assessment of Digital Health Literacy (Primary/Urgent Care)

The organization assesses the digital health literacy of its patient population.

This is a core requirement.

Evidence Documented process

Guidance The organization has a process for assessing the digital health literacy levels of its patient population to improve communication with patients.

The organization defines the assessment methodology it uses to assess literacy levels (e.g., eHEALS: The eHealth Literacy Scale,² developed by the NIH, or another tool.)

¹<https://doi.org/10.1016/j.amjmed.2016.01.008>

²<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1794004/>

Patient and Provider Experience

The organization assesses patient and provider experience of care delivered through virtual modalities, and implements quality improvement activities to address barriers to access.

PPE 1: Provider Availability (*Primary/Urgent Care*)

The organization tracks provider availability for virtual visits and defines parameters for response times.

This is a core requirement.

Evidence	Documented process, Report
Guidance	<p>The organization tracks providers' availability for virtual visits, which may include synchronous and asynchronous video, telephone and email, text or portal interactions, if applicable. The organization analyzes provider timeliness for synchronous and asynchronous video visits, to highlight delays or wait times before a visit begins.</p> <p>The organization defines parameters for availability and response times for each modality, and communicates expected response times to patients.</p>

PPE 2: Assessment of Provider Experience (*Primary/Urgent Care*)

The organization assesses provider experience with delivering care through virtual modalities.

This is a core requirement.

Evidence	Report or materials
Guidance	<p>The organization assesses provider experience delivering care through virtual modalities, including:</p> <ul style="list-style-type: none"> • Assessing ease of use and reliability of the virtual care platform. • Confidence in the organization's educational materials regarding patients' digital health literacy levels. • Barriers or restrictions to virtual care, including contracting or licensure requirements. • Adequate break time between patients, including standards of panel size (i.e., how many patients can be treated by the same provider). • Provider burnout.

PPE 3: Improve Provider Experience (Primary/Urgent Care)

The organization identifies an opportunity to improve provider experience, implements at least one intervention and measures the intervention's effectiveness.

This is a core requirement.

Evidence	Report, Implementation plan
Guidance	<p>The organization identifies at least one opportunity to improve provider experience delivering care through virtual modalities, then implements at least one intervention and measures its effectiveness.</p> <p>If the organization has not measured the effectiveness of the intervention, it may submit a plan outlining actions to complete the measurement.</p>

PPE 4: Assessment of Patient Experience (Primary/Urgent Care)

The organization assesses patients' experience with care provided in virtual settings.

This is a core requirement.

Evidence	Report or materials
Guidance	<p>The organization assesses the experience of the patient/family/caregiver receiving virtual care by conducting a survey (using any instrument, such as a written questionnaire [paper or electronic] or by telephone) that covers five dimensions:</p> <ol style="list-style-type: none"> 1. Access: <ul style="list-style-type: none"> • The virtual care platform used to conduct visits. • Language access, including audio and visual needs for patients with disabilities. • Appointment scheduling and availability. • Ease of access to EHRs, patient portals or patient health information. • Whether patients' preference for the visit type (synchronous and asynchronous video, telephone and email, text or portal interactions) was considered. 2. Communication: <ul style="list-style-type: none"> • Between providers and patients. • Between the organization (nonclinical staff) and patients. 3. Coordination of care: <ul style="list-style-type: none"> • Appropriateness of referrals. 4. Whole-person care: <ul style="list-style-type: none"> • Consideration of nonclinical social needs in care decisions. 5. Self-management support: <ul style="list-style-type: none"> • Adequate support for resources and tools provided by the organization or providers to facilitate care management.

Patient feedback must represent the patient population (including all relevant subpopulations), and may not be limited to patients of one clinician (of several), or to data from one payer (of several). If the organization provides care through the Hybrid Model, it differentiates survey results by in-person care and virtual care. The organization provides survey response rates.

PPE 5: Improve Patient Experience (Primary/Urgent Care)

The organization identifies an opportunity to improve patient experience, implements at least one intervention and measures the intervention's effectiveness.

This is a core requirement.

Evidence Report, Implementation plan

Guidance Based on the organization's assessment of patients' experience with care through virtual modalities, the organization identifies at least one opportunity to improve the patient experience, then implements at least one intervention and measures its effectiveness.

If the organization has not measured the intervention's effectiveness, it may submit a plan outlining actions to complete the measurement.

Data Sharing and Exchange

The organization has a process for exchanging and using data, and informs patients about the process. As part of the eligibility criteria, the organization complies with HIPAA and uses a HIPAA-compliant platform to deliver virtual care.

DSE 1: Data Systems (*Primary/Urgent Care*)

The organization uses data systems to store, send and receive patient data, and has a process for governing and tracking data.

This is a core requirement.

Evidence Documented process, Reports or materials

Guidance The organization demonstrates that it uses data systems to store, send and receive patient data and other clinical information with payer and provider organizations. The organization identifies the types of organizations and systems (i.e., health plans, health information exchanges [HIE], EHRs) with which it exchanges patient data that includes one of the following:

- Patient admission, discharge and transfer (ADT) data. (*Primary care only*)
- Patient eligibility, coverage and program entitlement data.
- Patient-specific health plan network access data.
- Patient-specific clinical and prescription data.
- Patient-specific social determinants, health equity and related self-reported data.
- Patient-specific health risk and other assessment data.

Exchange of data across organizations supports enhanced continuity and coordination of patient care. In electronic exchange, data are sent and received electronically through multiple mechanisms, including, but not limited to:

- A summary of care record accessible to another provider or care facility for care transitions (in compliance with the United States Office of the National Coordinator [ONC]—USCDI standards).¹
- ONC certified EHRs.
- HIEs.
- Qualified Health Information Network.
- Data warehouses and bulk/batch data transfers.
- Rendering of longitudinal patient records via application programming interface.

Organizations that can demonstrate participation, or sub-participation, in the Trusted Exchange Framework and Common Agreement (TEFCA) are eligible to receive Distinction in Interoperability.

¹<https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v4>

DSE 2: Use of Individual Data (Primary/Urgent Care)

The organization defines how it uses individual-level data.

This is a core requirement.

Evidence Documented process

Guidance The organization has a process for informing and receiving consent from patients to share data with other organizations. The organization defines how it uses individual-level data, which may include any of the following:

- Patient admission, discharge and transfer (ADT) data. *(Primary care only)*
- Patient eligibility, coverage and program entitlement data.
- Patient-specific health plan network access.
- Patient-specific clinical and prescription data.
- Patient-specific social determinants, health equity and related self-reported data.
- Patient-specific health risk and other assessment data.
- Data on quality gaps in care.
- Hierarchical Condition Category coding accuracy and completeness:
 - Any time patient data are transferred to another system.
 - Any time patient data are sold to a different organization.
 - Any time patient data are used internally.

DSE 3: Inform Patients of Data Use (Primary/Urgent Care)

The organization informs patients how it intends to use their data, and asks for their consent in plain language.

This is a core requirement.

Evidence Documented process

Guidance The organization informs patients (or their caregiver) how it intends to use their data, based on the criteria in DSE 2, and asks for consent using easily understandable language (i.e., language does not include technical or clinical abbreviations, acronyms or health care procedure codes that a layperson would not understand). The organization has a process for obtaining, tracking and storing patient consent, and for notifying patients if its process changes.

The organization may submit an audit trail of data transfers/receipts and related and documented internal controls and compliance testing in support of tracking and maintaining data security.

DSE 4: Privacy Protections for Data (*Primary/Urgent Care*)

The organization has policies and procedures for managing storage of, access to and use of patient data.

This is a core requirement.

Evidence Documented process

Guidance The organization governs and tracks receipt, removal and access to devices and media that contain patient data, or that may be used to access patient data. The organization's policies and procedures may be integrated with its HIPAA privacy policies, or may be separate if stated requirements are met.

The organization outlines how its EHR and related technical environments are protected, including:

- On-premises data and software.
- Hosted third-party cloud and software as a service (SaaS) licenses.

Policies and procedures outline permissible and impermissible data use, frequency of data back-ups and disaster recovery.