

**Requirements for NCQA
Recognition as a Patient-Centered Medical Home
9 Standards, 30 Elements, 183 Data Points**

**PPC 1: Access and Communication
points**

9

Element A: Access and Communication Processes

4 points

1. Scheduling each patient with a personal clinician for continuity of care.
2. Coordination visits with multiple clinicians and/or diagnostic tests during one trip.
3. Determining through triage how soon a patient needs to be seen.
4. Maintaining the capacity to schedule patients the same day they call
5. Scheduling same day appointments based on practice's triage of patients' conditions
6. Scheduling same day appointments based on patient's/family's requests.
7. Providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time.
8. Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week.
9. Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time.
10. Providing an interactive practice Web site
11. Making language services available for patients with limited English proficiency.
12. Identifying health insurance resources for patients/families without insurance.

Scoring – 100% -- Practice has written process for 9-12 items

Element B: Access and Communication Results

5 Points

1. Visits with assigned personal clinician for each patient.
2. Appointments scheduled to meet the standards in items 2-6 in 1A
3. Response times to meet standards for timely response to telephone requests.
4. Response times to meet its standards for timely response to e-mail and interactive Web request.
5. Language services for patients with limited English proficiency.

Scoring – 100% -- Practice's data meets 5 items

PPC 2: Patient Tracking and Registry Functions

21.00 Points

Element A: Basic System for Managing Patient Data

2 Points

1. Name
2. Date of Birth
3. Gender
4. Marital Status
5. Language preference
6. Voluntarily self-identified race/ethnicity
7. Address
8. Telephone (primary contact number)
9. E-mail address (or “none” for patients)
10. Internal ID
11. External ID
12. Emergency contact information
13. Current and past diagnoses
14. Dates of previous clinical visits
15. Billing codes for services
16. Legal guardian
17. Health insurance coverage
18. Patient/Family preferred method of communication.

Scoring – 100% -- 12-18 items were entered for 75-100% of patients.

Element B: Electronic System for Clinical Data

3 Points

1. Status of age-appropriate preventive services (immunizations; screenings, counseling)
2. Allergies and adverse reactions
3. Blood Pressure
4. Height
5. Weight
6. Body Mass Index (BMI) calculated
7. Laboratory test results
8. Presence of imaging results
9. Presence of pathology reports
10. Presence of advance directives.
11. Head circumference for patients 2 years or younger

Scoring – 100% -- System has 9-11 data fields

Element C: Use of Electronic Data

3 Points

The practice uses the fields listed in 2B consistently in patient records

Scoring – 100% 75-100% of patients seen in the past 3 months have at least 7 fields completed.

Element D: Organizing Clinical Data

6 Points

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

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

Scoring – 100% -- 75-100% of records of patients seen in the past 3 months include at least 3 tools with information documented.

Age-appropriate risk factor assessments may include but are not limited to:

- Uses of tobacco for age 12 and older
- Cognitive assessment for new patients over 70
- Use of alcohol for age 15 and over
- Risk of falls for the elderly
- Secondhand smoke
- Use of seat belts
- Use of bike helmets
- Mental health concerns
- Obesity
- At-risk sexual behavior
- Violence
- Family history of cancer or diabetes

Element E: Identifying important conditions**4.00 Points**

The practice uses an electronic or paper-based system to identify the following diagnoses and conditions.

1. Practice's most frequently seen diagnoses
2. Most important risk factors in the practice's patient population
3. Three conditions that are clinically important in the practice's patient population.

Scoring - 100% -- practice identifies 3 items.

Element F: Use of System for Population Management**3.0 Points**

The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, as follows:

1. Patients needing pre-visit planning (obtaining tests prior to visit, etc.)
2. Patients needing clinician review or action.
3. Patients on a particular medication
4. Patients needing reminds for preventive care.
5. Patients needing reminders for specific tests.
6. Patients needing reminders for follow-up visits such as for a chronic condition.
7. Patients who might benefit from care management support.

Scoring – 100% -- Practice uses information to take action on 5-7 items.

Examples of the populations management function are;

- Identify all patients who are taking a medication for which the practice received a warning.
- Identify all patients with ischemic vascular disease not taking appropriate medications.
- Identify all children with developmental delay
- Identify all children and adolescents with asthma
- Identify all women over 50 who are due for a mammogram.
- Identify all adult patients with elevated LDL for whom appropriate medication has not been prescribed.
- Identify all diabetic patients whose HgbA1c >9.
- Identify all patients with blood pressure >140/90.

PPC 3: Care Management

20 Points

Element A: Guidelines for Important Conditions

3 Points

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

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

Scoring – 100% -- Practice implements guidelines for 3 conditions.

Element B: Preventive Service Clinician Reminds

4 Points

1. Age-appropriate screening tests.
2. Age-appropriate immunizations (e.g., influenza, pediatric)
3. Age-appropriate risk assessments (e.g., smoking, diet, depression)
4. Counseling (e.g., smoking cessation).

Scoring – 100% -- Practice uses reminders for 4 items.

Element C: Practice Organization

3 Points

1. Non-physician staff remind patients of appointments and collect information prior to appointments.
2. Non-physician staff execute standing orders for medication refills, order tests and delivery routine preventive services
3. Non-physician staff educate patients/families about managing conditions.
4. Non-physician staff ordinate care with external disease management or case management organization.

Scoring – 100% Staff manage 4 items.

Element D: Care Management for Important Conditions 5 Points

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

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

Scoring – 100% -- 74% or more of patients seen in the past 3 months have at least 4 items documented.

Element E: Continuity of Care**5 Points**

The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities or patients who are transition to other care:

1. Identifies patients who receive care in facilities
2. Systematically sends clinical information to the facilities with patients as soon as possible.
3. Reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes.
4. Contacts patients after discharge from facilities
5. Provides or coordinates follow-up care to patients/families that have been discharged.
6. Coordinates care with external disease management or case management organizations, as appropriate
7. Communicates with patients/families receiving ongoing disease management or high risk case management.
8. Communicates with case managers for patients receiving ongoing disease management or high risk case management.
9. For patients transitioning to other care, develops a written transition plan in collaboration with the patient and family.
10. Aids in identifying a new primary care physician or specialties or consultants and offers ongoing consultation.

Scoring – 100 – Activities include 5-10 items)

PPC 4: Patient Self-Management Support

5 Points

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

Element A: Documenting Communication Needs

2 Points

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

1. Identify and display in the record the language preference of the patient and family
2. Assess both hearing and vision barriers to communication.

Scoring – 100% -- Practice assesses 2 items.

This element requires a systematic process that does not depend on practice staff remembering to assess the issues.

Element B: Self Management Support

4 Points

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

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

Score – 100% -- 75-100% of patients seen in the past 3 months have at least 3 activities documented.

PPC 5: Electronic Prescribing

8 Points

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

Element a: Electronic Prescription writing 3 Points

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

Scoring – 100% -- 75-100% of new prescriptions for patients seen in the last 3 months written with number 2

Element B: Prescribing Decision Support-Safety 3 Points

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

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

Scoring – 100% -- Practice uses 8 or more kinds of alerts and information

Element C: Prescribing Decision Support – Efficiency

2 Points

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

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

Scoring – 100% -- Practice uses 2 tools

PPC 6: Test Tracking

13 Points

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

Element A: Test Tracking and Follow-up

7 Points

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

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

Scoring – 100% -- Practice does 4-6 types of tracking and follow-up.

Element B: Electronic System for Managing Tests

6 Points

The practice uses an electronic system to

1. Order lab tests
2. Order imaging tests
3. Retrieve lab results directly from source
4. Retrieve imaging text reports directly from source
5. Retrieve images directly from the source
6. Route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison
7. Flag duplicate tests ordered
8. Generate alerts for appropriateness of tests ordered.

Scoring – 100% practice uses 5-8 functions.

PPC 7: Referral Tracking

4 Points

Element A: Referral Tracking

4 Points

The practice uses a system that includes the following information for its referrals:

- | | |
|---------------------|---------------------------|
| 1. Origination | 3. Tracking Status |
| 2. Clinical Details | 4. Administrative details |

Scoring – 100% -- Practice uses system that includes all 4 items.

PPC 8: Performance Reporting for Improvement

15 Points

Element A: Measurements of Performance

3 Points

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

1. Clinical process (e.g., percentage of women 50+ with mammograms or childhood vaccination rates)
2. Clinical outcomes (e.g. HbA1c levels for diabetics)
3. Service data (e.g. backlogs or wait times)
4. Patient safety issues (e., medication errors)

Scoring – 100% -- Practice measures at least 2 types of performance

Element B: Patient Experience Data

3 Points

The practice collects data on patient experience with care in the following areas

1. Patient access to care
2. Quality of physician communication
3. Patient/family confidence in self care
4. Patient/family satisfaction with care

Scoring – 100% -- Practice collects data on 3-4 areas.

Element C: Reporting to Physicians

3 Points

The practice reports on performance measures in 8A and 8B:

1. Across the practice
2. By individual physician

Scoring – 100% -- Practice reports to physicians results both across the practice and by physician.

Element D: Setting Goals and Taking Action

3 Points

The practice uses performance data to:

1. Set goals based on measurement results reference in Element 8 A
2. Take action where identified to improve performance of individual physicians or of the practice as a whole

Scoring – 100% -- Practice does 2 items

Element E: Reporting Standardized Measures

2 Points

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

Scoring – 100% -- Practices produces reports using 10 or more nationally approved clinical quality performance measures (National Quality Forum)

Element F: Electronic Reporting – External Entities

1 Point

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

Scoring – 100% -- Practice transmits 10 or more nationally approved performance measures to an external entity.

PPC 9: Advanced Electronic Communications

4 Points

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

Element A: Availability of interactive web site

1 Point

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

1. Request appointments by reviewing clinicians schedules
2. Request referrals
3. Request test results
4. Request Prescription refills
5. See elements of their medical records
6. Import elements of their medical record into a personal health record

Scoring – 100% -- Practice provides 5-6 items.

Element B: Electronic patient Identification

2 Points

The practice combines use of electronic information and clinical decision-support to contact the following types of patients, once identified by e-mail

1. Patients needing clinical review or action
2. Patients on a particular medication
3. Patients needing preventive care
4. Patients needing specific tests
5. Patients needing follow-up visits
6. Patients who might benefit from disease or case management support.

Scoring – 100% -- Practice uses electronic information and communications for 5-6 items.

Element C: Electronic Care Management Support

1 Point

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

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

Scoring – 100% -- Practices uses electronic communication for 2 items.