2017 STANDARDS PREVIEW

# Patient-Centered Medical Home Recognition

## The redesigned PCMH 2017 requirements focus on assessing a practice's transformation into a medical home and specify goals for improvement. There is a new recognition requirement structure: concepts, competencies and criteria.

- Concepts are the foundation on which a practice builds a medical home.
- Competencies organize the criteria in each concept area.
- Criteria are the individual structures, functions and activities that indicate a practice is operating as a medical home.

We have also eliminated the levels of recognition, points and must-pass elements. To achieve recognition under PCMH 2017, practices must 1) meet all core criteria and 2) earn 25 credits in elective criteria across 5 of 6 concepts. This ensures a minimum set of capabilities and gives practices the flexibility to focus on activities that not only mean the most to their patient population, but are feasible to accomplish with regard to their resources and the resources of their community.

The changes also complement the redesign of the overall program and of the recognition process specifically. Of note is the introduction of a series of virtual reviews to achieve recognition. Rather than coordinating and submitting a large number of documents for evaluation by a reviewer, practices may demonstrate compliance in other ways and "tell the story" of their PCMH transformation.

The final PCMH 2017 standards will include detailed explanations, evidence requirements and relevant examples to guide practices through their recognition. The final PCMH 2017 requirements will be released when the updated product launches on Monday April 3, 2017.

For more information, currently recognized practices may contact NCQA through My NCQA at https://my.ncqa.org. Practices considering recognition may contact NCQA at www.ncqa.org/pcmhinfo

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Measuring quality.
Improving health care.

## How to read the new standards in this preview document:

**Concept**: A brief title describing the criteria; uses a two-letter abbreviation (XX).

**Competency**: A brief description of criteria subgroup, organized within the broader concept.

**Criteria**: A brief statement highlighting PCMH requirements.

**TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)**

Intent: The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

**Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.**

**TC1 * (Core)** Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.

* New Criteria in PCMH 2017

All criteria are numbered consecutively within their respective concept. Criteria are also labeled with their scoring designation:

- Core = Core criteria
- 1 Credit = Elective criteria worth 1 credit
- 2 Credits = Elective criteria worth 2 credits

Practices must meet all core criteria and earn at least 25 elective credits across five different concept areas to achieve NCQA PCMH Recognition.

Criteria with this designation are new to the PCMH program. Many PCMH 2017 criteria are based on PCMH 2014 requirements. The language may have slight modifications from the original, but the intent remains the same.

**Intent**: A brief statement describing the concept goals and intent.

## TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)

Intent: The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

**Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.**

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| **TC1 * (Core)** | Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities. |
| **TC2 (Core)** | Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions. |
| **TC3 * (1 Credit)** | The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges). |
| **TC4 * (2 Credits)** | Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees. |
| **TC5 (2 Credits)** | The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies. |

**Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.**

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| **TC6 (Core)** | Has regular patient care team meetings or a structured communication process focused on individual patient care. |
| **TC7 (Core)** | Involves care team staff in the practice's performance evaluation and quality improvement activities. |
| **TC8 * (2 Credits)** | Has at least one care manager qualified to identify and coordinate behavioral health needs. |

**Competency C: The practice communicates and engages patients on expectations and their role in the medical home model of care.**

***No Elective Criteria***

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| **TC9 (Core)** | Has a process for informing patients/ families/caregivers about the role of the medical home and provides patients/ families/caregivers materials that contain the information. Such as after-hours access, practice scope of services, evidence-based care, education and self-management support |

* New Criteria in PCMH 2017

## KNOWING AND MANAGING YOUR PATIENTS (KM)

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 population needs and provision of culturally and linguistically appropriate services.

**Competency A: Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals.**

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| **KM1 (Core)** | Documents an up-to-date problem list for each patient with current and active diagnoses |
| **KM2 (Core)**<br>***(F) is new**<br>***(G) is new** | Comprehensive health assessment includes (all items required):<br>A. Medical history of patient and family<br>B. Mental health/substance use history of patient and family<br>C. Family/social/cultural characteristics<br>D. Communication needs.<br>E. Behaviors affecting health<br>F. Social Functioning *<br>G. Social Determinants of Health *<br>H. Developmental screening using a standardized tool.<br>(NA for practices with no pediatric population under 30 months of age.)<br>I. Advance care planning. (NA for pediatric practices) |
| **KM3 (Core)** | Conducts depression screenings for adults and adolescents using a standardized tool. |
| **KM4 * (1 Credit)** | Conducts behavioral health screenings and/or assessments using a standardized tool. (implement two or more)<br>A. Anxiety<br>B. Alcohol Use Disorder<br>C. Substance Use Disorder<br>D. Pediatric Behavioral Health Screening<br>E. Post-Traumatic Stress Disorder<br>F. ADHD<br>G. Postpartum Depression |
| **KM5 * (1 Credit)** | Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners. |
| **KM6 (1 Credit)** | Identifies the predominant conditions and health concerns of the patient population. |
| **KM7 * (2 Credits)** | Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data. |
| **KM8 * (1 Credit)** | Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials. |

* New Criteria in PCMH 2017

## KNOWING AND MANAGING YOUR PATIENTS (KM)

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 population needs and provision of culturally and linguistically appropriate services.

**Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.**

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| **KM9 (Core)** | Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population. |
| **KM10 (Core)** | Assesses the language needs of its population. |
| **KM11 (1 Credit)**<br>***(A) is new**<br>***(C) is new** | Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2)<br>A. Target population health management on disparities in care*<br>B. Address health literacy of the practice<br>C. Educate practice staff in cultural competence* |

**Competency C: The practice proactively addresses the care needs of the patient population to ensure needs are met.**

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| **KM12 (Core)** | Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (practice must report at least 3 categories):<br>A. Preventive care services<br>B. Immunizations<br>C. Chronic or acute care services<br>D. Patients not recently seen by the practice |
| **KM13 * (2 Credits)** | Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines. [Specifics yet to be defined but at minimum includes DRP/HSRP recognition by NCQA.] |

**Competency D: The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.**

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| **KM14 (Core)** | Reviews and reconciles medications for more than 80 percent of patients received from care transitions. |
| **KM15 (Core)** | Maintains an up-to-date list of medications for more than 80 percent of patients. |
| **KM16 (1 Credit)** | Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers. |
| **KM17 (1 Credit)** | Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment. |

* New Criteria in PCMH 2017

## KNOWING AND MANAGING YOUR PATIENTS (KM)

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 population needs and provision of culturally and linguistically appropriate services.

**Competency D: The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.**

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| **KM18 * (1 Credit)** | Reviews controlled substance database when prescribing relevant medications. |
| **KM19 * (2 Credits)** | Systematically obtains prescription claims data in order to assess and address medication adherence. |

**Competency E: The practice incorporates evidence- based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients.**

***No Elective Criteria***

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| **KM20 (Core)** | Implements clinical decision support following evidence-based guidelines for care of:<br>(Practice must demonstrate at least 4 criteria.)<br>A. Mental health condition<br>B. Substance use disorder<br>C. A chronic medical condition<br>D. An acute condition<br>E. A condition related to unhealthy behaviors<br>F. Well child or adult care<br>G. Overuse/appropriateness issues |

**Competency F: The practice identifies/considers and establishes connections to community resources to collaborate and direct patients to needed support.**

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| **KM21 * (Core)** | Uses information on the population served by the practice to prioritize needed community resources. |
| **KM22 (1 Credit)** | Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs. |
| **KM23 * (1 Credit)** | Provides oral health education resources to patients. |
| **KM24 (1 Credit)** | Adopts shared decision-making aids for preference-sensitive conditions. |
| **KM25 * (1 Credit)** | Engages with schools or intervention agencies in the community. |
| **KM26 (1 Credit)** | Routinely maintains a current community resource list based on the needs identified in Core KM21. |

* New Criteria in PCMH 2017

## KNOWING AND MANAGING YOUR PATIENTS (KM)

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 population needs and provision of culturally and linguistically appropriate services.

**Competency F: The practice identifies/considers and establishes connections to community resources to collaborate and direct patients to needed support.**

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| **KM27 (1 Credit)** | Assesses the usefulness of identified community support resources. |
| **KM28 * (2 Credits)** | Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists). |

* New Criteria in PCMH 2017

## PATIENT-CENTERED ACCESS AND CONTINUITY (AC)

Intent: PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

**Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs.**

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| **AC1 * (Core)** | Assesses the access needs and preferences of the patient population. |
| **AC2 (Core)** | Provides same-day appointments for routine and urgent care to meet identified patients' needs. |
| **AC3 (Core)** | Provides routine and urgent appointments outside regular business hours (generally considered 8-5 M-F) to meet identified patients' needs. |
| **AC4 (Core)** | Provides timely clinical advice by telephone. |
| **AC5 (Core)** | Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record. |
| **AC6 (1 Credit)** | Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms. |
| **AC7 (1 Credit)** | Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results. |

* New Criteria in PCMH 2017

## PATIENT-CENTERED ACCESS AND CONTINUITY (AC)

Intent: PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

**Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs.**

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| **AC8 (1 Credit)** | Has a secure electronic system for two-way communication to provide timely clinical advice. |
| **AC9 * (1 Credit)** | Uses information on the population served by the practice to assess equity of access that considers health disparities. |

**Competency B: Practices support continuity through empanelment and systematic access to the patient's medical record.**

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| **AC10 (Core)** | Helps patients/families/caregivers select or change a personal clinician. |
| **AC11 (Core)** | Sets goals and monitors the percentage of patient visits with selected clinician or team. |
| **AC12 (2 Credits)** | Provides continuity of medical record information for care and advice when the office is closed. |
| **AC13 * (1 Credit)** | Reviews and actively manages panel sizes. |
| **AC14 * (1 Credit)** | Reviews and reconciles panel based on health plan or other outside patient assignments. |

* New Criteria in PCMH 2017

## CARE MANAGEMENT AND SUPPORT (CM)

Intent: The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

**Competency A: The practice systematically identifies patients that would benefit most from care management.**

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| **CM1 (Core)** | Considers the following in establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):<br>A. Behavioral health conditions<br>B. High cost/high utilization<br>C.Poorly controlled or complex conditions<br>D. Social determinants of health<br>E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver |
| **CM2 (Core)** | Monitors the percentage of the total patient population identified through its process and criteria. |
| **CM3* (2 Credits)** | Applies a comprehensive risk- stratification process to entire patient panel in order to identify and direct resources appropriately. |

**Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop care plans that address barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart. Demonstration of such may be through reports, file review or live demonstration of case examples.**

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| **CM4 (Core)** | Establishes a person-centered care plan for patients identified for care management. |
| **CM5 (Core)** | Provides written care plan to the patient/family/caregiver for patients identified for care management. |
| **CM6 (1 Credit)** | Documents patient preference and functional/lifestyle goals in individual care plans. |
| **CM7 (1 Credit)** | Identifies and discusses potential barriers to meeting goals in individual care plans. |
| **CM8 (1 Credit)** | Includes a self-management plan in individual care plans. |
| **CM9 * (1 Credit)** | Care plan is integrated and accessible across settings of care. |

* New Criteria in PCMH 2017

## CARE COORDINATION AND CARE TRANSITIONS (CC)

Intent: The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood

**Competency A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.**

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| **CC1 (Core)** | The practice systematically manages lab and imaging tests by:<br>A. Tracking lab tests until results are available, flagging and following up on overdue results<br>B. Tracking imaging tests until results are available, flagging and following up on overdue results<br>C. Flagging abnormal lab results, bringing them to the attention of the clinician<br>D. Flagging abnormal imaging results, bringing them to the attention of the clinician<br>E. Notifying patients/families/caregivers of normal lab and imaging test results<br>F. Notifying patients/families/caregivers of abnormal lab and imaging test results |
| **CC2 (1 Credit)** | Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for practices that do not care for newborns). |
| **CC3 * (2 Credits)** | Uses clinical protocols to determine when imaging and lab tests are necessary. |

**Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.**

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| **CC4 (Core)** | The practice systematically manages referrals by:<br>A. Giving the consultant or specialist the clinical question, the required timing and the type of referral<br>B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan<br>C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports |
| **CC5 * (2 Credits)** | Uses clinical protocols to determine when a referral to a specialist is necessary. |
| **CC6 * (1 Credit)** | Identifies the specialists/specialty types most commonly used by the practice |
| **CC7 (2 Credits)** | Considers available performance information on consultants/specialists when making referral recommendations. |
| **CC8 (1 Credit)** | Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care. |
| **CC9 (2 Credits)** | Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care. |

* New Criteria in PCMH 2017

## CARE COORDINATION AND CARE TRANSITIONS (CC)

Intent: The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood

**Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.**

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| **CC10 (2 Credits)** | Integrates behavioral healthcare providers into the care delivery system of the practice site. |
| **CC11 (1 Credit)** | Monitors the timeliness and quality of the referral response. |
| **CC12 (1 Credit)** | Documents co-management arrangements in the patient's medical record. |
| **CC13 * (2 Credits)** | Engages with patients regarding cost implications of treatment options |

**Competency C: The practice connects with other health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.**

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| **CC14 (Core)** | Systematically identifies patients with unplanned hospital admissions and emergency department visits. |
| **CC15 (Core)** | Shares clinical information with admitting hospitals and emergency departments. |
| **CC16 (Core)** | Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit. |
| **CC17 * (1 Credit)** | Systematic ability to coordinate with acute care settings after hours through access to current patient information. |
| **CC18 (1 Credit)** | Exchanges patient information with the hospital during a patient's hospitalization. |
| **CC19 (1 Credit)** | Implements process to consistently obtain patient discharge summaries from the hospital and other facilities. |
| **CC20 (1 Credit)** | Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transferring in to/out of the practice (e.g., transitioning from pediatric care to adult care). |
| **CC21 (Maximum 3 Credits)** | Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more):<br>A. Regional health information organization (RHIO) or other Health information exchange source that enhances ability to manage complex patients<br>B. Immunization registries or immunization information systems<br>C. Summary of care record to other providers or care facilities for care transitions |

* New Criteria in PCMH 2017

## 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 the staff and patients/families/caregivers in the quality improvement activities.

**Competency A: The practice measures to understand current performance and to identify opportunities for improvement.**

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| **QI1 (Core)**<br>* (D) is New | Monitors at least five clinical quality measures across the four categories<br>(Must monitor at least 1 measure of each type).<br>A. Immunization measures<br>B. Other preventive care measures<br>C. Chronic or acute care clinical measures<br>D. Behavioral health measures* |
| **QI2 (Core)** | Monitors at least two measures of resource stewardship.<br>(Must monitor at least 1 measure of each type).<br>A. Measures related to care coordination<br>B. Measures affecting health care costs |
| **QI3 (Core)** | Assesses performance on availability of major appointment types to meet patient needs and preferences for access. |
| **QI4 (Core)** | Monitors patient experience through<br>A. Quantitative data: The practice conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:<br>• Access,<br>• Communication,<br>• Coordination,<br>• Whole person care, Self-management support and Comprehensiveness<br>B. Qualitative data: The practice obtains feedback from patients/families/caregivers through qualitative means |
| **QI5 (1 Credit)** | Assesses health disparities using performance data stratified for vulnerable populations.<br>(Must choose one from each section)<br>A. Clinical Quality<br>B. Patient Experience |
| **QI6 (1 Credit)** | The practice uses a standardized, validated patient experience survey tool with benchmarking data available |
| **QI7 (2 Credits)** | The practice obtains feedback on experiences of vulnerable patient groups. |

* New Criteria in PCMH 2017

## 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 the staff and patients/families/caregivers in the quality improvement activities.

**Competency B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.**

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| **QI8 (Core)**<br>*** (D) is New** | Sets goals and acts to improve upon at least three measures across at least three of the four categories.<br>A. Immunization measures<br>B. Other preventive care measures<br>C. Chronic or acute care clinical measures<br>D. Behavioral health measures* |
| **QI9 (Core)** | Sets goals and acts to improve upon at least one measure of resource stewardship.<br>A. Measures related to care coordination<br>B. Measures affecting health care costs |
| **QI10 (Core)** | Sets goals and acts to improve on availability of major appointments types to meet patient needs and preferences. |
| **QI11 (Core)** | Sets goals and acts to improve on at least one patient experience measure. |
| **QI12 (2 Credits)** | Achieves improved performance on at least 2 performance measures. |
| **QI13 (1 Credit)** | Sets goals and acts to improve disparities in care or service on at least 1 measure. |
| **QI14 (2 Credits)** | Achieves improved performance on at least 1 measure of disparities in care or service. |

**Competency C: The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.**

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| **QI15 (Core)** | Reports practice-level or individual clinician performance results within the practice for measures reported by the practice. |
| **QI16 (1 Credit)** | Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice. |
| **QI17 (2 Credits)** | Involves patient/family/caregiver in quality improvement activities. |
| **QI18 (2 Credit)** | Reports clinical quality measures to Medicare or Medicaid agency |
| **QI19 * (Maximum 2 credits)** | The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits)<br>A. Practice engages in up-side risk contract (1 credit)<br>B. Practice engages in two-sided risk contract (2 credits) |

* New Criteria in PCMH 2017