Change Concepts for Practice Transformation AND 2014 NCQA PCMH Standards Crosswalk to 2017 NCQA Standards				
	Change Concept Element	**2014 NCQA PCMH Standards**	**2014 --> 2017**	**2017 NCQA Standards**
ENGAGED LEADERSHIP	**1a**. Provide visible and sustainable leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.	**PCMH 2: Team-Based Care, Element D: The Practice Team (Must Pass)** The Practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 8. Holding scheduled team meetings to address practice functioning	2:D: 1-2 = TC-02 2:D:8 = no equivalent, supports TC-02	**TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions.
	1b. Ensure that the PCMH transformation effort has the time and resources needed to be successful	**PCMH 2: Team-Based Care, Element D: The Practice Team** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior change. 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning	2:D: 1-2 = TC-02 2:D:3-4= TC-06 2:D:4-8 = NO EQUIVALENT, supports TC-02	**TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions. **TC-06 (Core):** Has regular patient care team meetings or a structured communication process focused on individual patient care. (i.e. Huddles)
	1c. Ensure that providers and other care team members have protected time to conduct activities	**PCMH 2: Team-Based Care, Element D: The Practice Team (must pass)** 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 8. Holding regular team meetings addressing practice	2:D:3 =TC-06 2:D:9 = TC-07 2:D:8 = NO EQUIVALENT	**TC-06 (Core):** Has regular patient care team meetings or a structured communication process focused on individual patient care. (i.e. Huddles) **TC-07 (Core):** Involves care team staff in the

	beyond direct patient care that are consistent with the medical home model.	functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities		practice's performance evaluation and quality improvement activities.
	1d. Build the practice's values on creating a medical home for patients into staff hiring and training processes.	**PCMH 2: Team-Based Care, Element D: The Practice Team** 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior change. 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities	2:D:1-2 = TC-06 2:D:5-8 = NO EQUIVALENT, supports TC-02 2:D:9= TC-07	**TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions. **TC-07 (Core):** Involves care team staff in the practice's performance evaluation and quality improvement activities.
QUALITY IMPROVEMENT	**2a**. Choose and use a formal model for quality improvement	**PCMH 6: Performance Measurement and Quality Improvement, Element D: Implement Continuous Quality Improvement (Must pass)** 1. Set goals and analyze at least three clinical quality measures from Element A 2. Act to improve at least three clinical quality measures from Element A 3. Set goals and analyze at least one measure from Element B 4. Act to improve at least one measure from Element B 5. Set goals and analyze at least 1 patient experience measure from Element C 6. Act to improve at least 1 patient experience measure from Element C 7. Set goals and address at least one identified disparity	6:D:1-2 = QI-08 6:D:3-4= QI-09 6:D:5-6 = QI-11 6:D:7 = QI=13 (1 CREDIT) 6:E:1 = NO EQUIVALENT 6:E:2-4= QI-12 (2 CREDITS)	**QI-08 (Core):** Sets goals and acts to improve upon at least three measures across at least three of the four categories: A. Immunization measures, B. Other preventive care measures, C. Chronic or acute care clinical measures, D. Behavioral health measures **QI-09 (Core):** Sets goals and acts to improve performance on at least one measure of resource stewardship: A. Measures related to care coordination B. Measures affecting health care costs. **QI-11 (Core):** Sets goals and acts to improve performance on at least one patient

		in care/service for identified vulnerable populations **Element E: Demonstrate Continuous Quality Improvement** The practice demonstrates continuous quality improvement by: 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 2. Achieving improved performance on at least 2 clinical quality measures 3. Achieving improved performance on one utilization or care coordination measure 4. Achieving improved performance on at least one patient experience measure		experience measure. **QI-13 (1 Credits):** Sets goals and acts to improve disparities in care or services on at least one measure. **QI-12 (2 Credits):** Achieves improved performance on at least two performance measures.
	2b. Establish and monitor metrics to evaluate routine improvement efforts and outcomes; ensure all staff members understand the metrics for success.	**PCMH 6: Performance Measurement and Quality Improvement, Element A: Measure Clinical Quality Performance** At least annually, the practice measures or receives data on: 1. At least 2 immunization measures 2. At least 2 other preventive care measure 3. At least 3 chronic or acute care clinical measures 4. Performance data stratified for vulnerable populations (to assess disparities in care). **PCMH 6, Element B: Measure Resource Use and Care Coordination** At least annually, the practice measures or receives quantitative data on: 1. At least 2 measures related to care coordination 2. At least 2 measures affecting health care costs **Element C: Measure Patient/Family Experience** At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least 3 of the following categories: • Access	6:A:1-3 = QI-01 (CORE) 6:A:4 = QI-05 (1 CREDIT) 6:B:1-2 = QI-02 (CORE) 6:C:1 = QI-04A (CORE) 6:C:2= QI-06 (1 CREDIT) 6:C:3 = QI-07 (2 CREDITS) 6:C:4 = QI-04B (CORE) 6:D:1-2 = QI-08 (CORE) 6:D:3-4 = QI-09	**QI-01 (Core):** Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type): **A**. Immunization measure, B. Other preventive care measures, C. Chronic or acute care clinical measures, D. Behavioral health measures. **QI-05 (1 Credit):** Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A: Clinical Quality B: Patient Experience **QI-02 (Core):** Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): **A**. Measures related to care coordination. **B**. Measures affecting health care costs. **QI-04 (Core):** Monitors patient experience through: **A.** Quantitative data. Conducts a survey to evaluate patient/family/caregiver experiences across at least three dimensions such as

		• Communication • Coordination • Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS clinician and Group Survey Tool 3. The practice obtains feedback on the experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means **Element D: Implement Continuous Quality Improvement (MUST PASS)** The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least 3 clinical quality measures from Element A 2. Act to improve at least 3 clinical quality measures from Element A 3. Set goals and analyze at least 1 measure from Element B 4. Act to improve at least 1 clinical measure from Element B 5. Set goals and analyze at least 1 patient experience measure from Element C 6. Act to improve at least 1 patient experience measure from Element C 7. Set goals and address at least 1 identified disparity in care/service for identified vulnerable populations **Element E: Demonstrate Continuous Quality Improvement** The practice demonstrates continuous quality improvement by: 5. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 6. Achieving improved performance on at least 2 clinical quality measures 7. Achieving improved performance on one utilization	(CORE) 6:D:5-6 = QI-11 (CORE) 6:D:7 = QI-13 (1 CREDIT) 6:E:1 = NO EQUIVALENT 6:E:2-4 = QI-12 (2 CREDITS) 6:F:1-2 = QI-15 (CORE) 1:A:1 = AC-02 (CORE) 1:A:2 = AC-03 (CORE) 1:A:3 = AC-06 (1 CREDIT) 1:A:4 = QI-03 (CORE) 1:A:5 = NO EQUIVALENT 1:A:6 = QI-10 (CORE) 2:A:2 = AC-11 (CORE)	Access, Communication, Coordination, Whole-person care, self-management support and comprehensiveness. **QI-06 (1 Credit):** The practice uses a standardized, validated patient experience survey tool with benchmarking data available. **QI-07 (2 Credits):** The practice obtains feedback on experiences of vulnerable patient groups. **QI-04 (Core):** Monitors patient experience through: **B.** Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means. **QI-08 (Core):** Sets goals and acts to improve upon at least three measures across at least three of the four categories: **A.** Immunization measures, **B.** Other preventive care measures, **C.** Chronic or acute care clinical measures, **D.** Behavioral health measures **QI-09 (Core):** Sets goals and acts to improve performance on at least one measure of resource stewardship: **A.** Measures related to care coordination **B.** Measures affecting health care costs. **QI-11 (Core):** Sets goals and acts to improve performance on at least one patient experience measure. **QI-13 (1 Credits):** Sets goals and acts to improve disparities in care or services on at

		or care coordination measures 8. Achieving improved performance on at least one patient experience measure **Element F: Report Performance** The practice produces performance data reports using measures from Elements A, B, and C and shares: 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice **PCMH 1: Patient-Centered Access, Element A: Patient-Centered Appointment Access (MUST PASS)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting on identified opportunities to improve access **PCMH 2: Team-Based Care, Element A: Continuity** The practice provides continuity of care for patients/families by: 2. Monitoring the percentage of patient visits with selected clinician or team **PCMH 2: Team-Based Care, Element D: The Practice Team (MUST PASS)** The practice uses a team to provide a range of patient care services by: 9. Involving care team staff in the practice's performance evaluation and quality improvement	2:D:9= TC-07 (CORE) 2:D:10 = QI-17 (2 CREDITS)	least one measure. **QI-12 (2 Credits):** Achieves improved performance on at least two performance measures. **QI-15 (Core):** Reports practice-level or individual clinician performance results within the practice for measures reported by the practice. **AC-02 (Core):** The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs. **AC-03 (Core):** The practice offers routine and urgent care appointments outside typical business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch. **AC-06 (1credit):** Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms. **QI-03 (Core):** Assesses performance on availability of major appointment types to meet patient needs and preferences for access.

		activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council		**QI-10 (Core):** Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences. **AC-11 (Core):** Sets goals and monitors the percentage of patient visits with the selected clinician or team. **TC-07 (core):** Involves care team staff in the practice's performance evaluation and quality improvement activities. **QI-17 (2 Credits):** Involves patient/family/caregiver in quality improvement activities.
	2c. Ensure that patients, families, providers and care team members are involved in quality improvement activities.	**PCMH 2: Team-Based Care, Element D: The Practice Team (MUST-PASS)** The practice uses a team to provide a range of patient care services by: 9 Involving care team staff in the practice's performance evaluation and quality improvement activities 10 Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council **PCMH 6: Performance Measurement and Quality Improvement, Element F: Report Performance** The practice produces performance data reports using measures from Elements A, B and C and shares: 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice 3. Individual clinician or practice-level performance results publicly	2:D:9= TC-07 (CORE) 2:D:10 = QI-17 (2 CREDITS) 6:F: 1-2 = QI-15 (CORE) 6:F:3-4 = QI-16 (1 CREDIT)	**TC-07 (Core):** Involves care team staff in the practice's performance evaluation and quality improvement activities. **QI-17 (2 Credits):** Involves patient/family/caregiver in quality improvement activities. **QI-15 (Core):** Reports practice-level or individual clinician performance results within the practice for measures reported by the practice. **QI-16 (1 Credit):** Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice.

		4. Individual clinician or practice-level performance results with patients		
	2d. Optimize use of health information technology to meet Meaningful Use criteria.	All Meaningful Use Stage 2 requirements, both core and menu, are embedded within the NCQA 2014 PCMH Standards and Guidelines (**1C1-4; 3A1-5; 3B1-8, 10 and 11; 3D1-3; 3E stem; 4C1; 4D1-3; 4E1; 5A7-10; 5B7; 5C7; 6G1-7 and 10.)**		In Order: No Equivalent; no equivalent; KM-01 (core), no equivalent; KM-12 (core); KM-20 (core); CM-01 (core); no equivalent; no equivalent; no equivalent; CC-21C (1 of 3 credits); CC-21 C (1 of 3 credits); TC-05 (2 credits), no equivalent, QI-18 (2 credits), CC-21B (1 of 3 credits), KM-12 (core)
EMPANELMENT	**3a**. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.	**PCMH 2: Team-Based Care, Element A: Continuity** The practice provides continuity of care for patients/families by: 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team	2:A:1 = AC-10 (CORE) 2:A:2 = AC-11 (CORE)	**AC-10 (Core):** Helps patients/families/caregivers select or change a personal clinician. **AC-11 (Core):** Sets goals and monitors the percentage of patient visits with the selected clinician or team.

	3b. Assess practice supply and demand, and balance patient load accordingly.	**PCMH 1: Patient-Centered Access, Element A: Patient-Centered Appointment Access (MUST PASS)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting to identify opportunities to improve access **PCMH 2: Team-Based Care, Element A: Continuity** The practice provides continuity of care for patients/families by: 2 Monitoring the percentage of patient visits with selected clinician or team	1:A:1 = AC-02 (CORE) 1:A:2 = AC-03 (CORE) 1:A:3 = AC-06 (1 CREDIT) 1:A:4 = QI-03 (CORE) 1:A:5 = NO EQUIVALENT 1:A:6 = QI-10 (CORE) 2:A:2 = AC-11 (Core)	**AC-02 (Core):** The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs. **AC-03 (Core):** The practice offers routine and urgent care appointments outside typical business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch. **AC-06 (1 Credit):** Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms. **QI-03 (Core):** Assesses performance on availability of major appointment types to meet patient needs and preferences for access. **QI-10 (Core):** Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences. **AC-11 (Core):** Sets goals and monitors the percentage of patient visits with the selected clinician or team.

	3c. Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.	**PCMH 3: Population Health Management,** **Element A: Patient Information (All factors)** **Element B: Clinical Data (All factors)** **Element C: Comprehensive Health Assessment (All factors)** **Element D: Use Data for Population Management (MUST PASS) (All factors)** **PCMH 4:Care Management Support, Element A: Identify Patients for Care Management** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria	3:A:1-14 = NO EQUIVALENT 3:B:1 = KM-01 (CORE) 3:B:2-8,10,11 = NO EQUIVALENT 3:B:9 = KM 15 (CORE) 3:C:1 = NO EQUIVALENT 3:C:2-8 = KM-02 (CORE), F/G are new 3:C:9 = KM-03 (CORE) 3:C:10 = KM 11B (1 CREDIT) 3:D:1-4 = KM-12 (CORE) 3:D:5 = NO EQUIVALENT 3:E1, 2-6 = KM-20 (CORE) 4:A:1-5 = CM-01 (CORE)	**KM-01 (Core):** Documents an up-to-date problem list for each patient with current and active diagnoses. **KM-15 (Core):** Maintains and up-to-date list of medications for more than 80 percent of patients. **KM-02 (Core):** Comprehensive health assessment includes A-I items (all items required). **KM-03 (Core):** Conducts depression screenings for adults and adolescents using a standardized tool. **KM-11 (1 credit):** Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target population health management on disparities in care* **B. Address health literacy of the practice** **KM-12 (Core):** The practice proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories): A. Preventive care services B. Immunizations C. Chronic or acute care services D. Patients not recently seen by the practice. **KM-20 (Core):** Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least

			4:A:6 = CM-02 (CORE)	four criteria): A. Mental health condition, B. Substance use disorder, C. A chronic medical condition, D. An acute condition, E. A condition related to unhealthy behaviors, F. Well child or adult care, G. Overuse/appropriateness issues. **CM-01 (Core):** Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions, B. High cost/high utilization, C. Poorly controlled or complex conditions, D. Social determinants of health, E. Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff, patient/family/caregiver. **CM-02 (Core):** Monitors the percentage of the total patient population identified through its process and criteria.
CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS	**4a.** Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel.	**PCMH 2: Team-Based Care, Element D: The Practice Team (MUST-PASS)** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 5 Training and assigning members of the care team to coordinate care for individual patients 6 Training and assigning members of the care team to support patients/families/caregivers in self-	2:D:1-2 = TC-02 (CORE) 2:D:3 = TC-06 (CORE) 2:D:4-8 = NO EQUIVALENT, SUPPORTS TC-02	**TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions. **TC-06 (Core):** Has regular patient care team meetings or a structured communication process focused on individual patient care. (i.e. Huddles)

		management, self-efficacy and behavior change 7 Training and assigning members of the care team to manage the patient population 8 Holding regular team meetings addressing practice functioning		
	4b. Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.	**PCMH 2: Team-Based Care, Element A: Continuity** The practice provides continuity of care for patients/families by: 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team	2:A:1 = AC-10 (CORE) 2:A:2 = AC-11 (CORE)	**AC-10 (Core):** Helps patients/families/caregivers select or change a personal clinician. **AC-11 (Core):** Sets goals and monitors the percentage of patient visits with the selected clinician or team.
	4c. Ensure that patients are able to see their provider or care team whenever possible.	**PCMH 2: Team-Based Care, Element A: Continuity** The practice provides continuity of care for patients/families by: 2 Monitoring the percentage of patient visits with selected clinician or team **PCMH 1: Patient-Centered Access, Element A: Patient-Centered Appointment Access (MUST PASS)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments	2:A:2 = AC-11 (CORE) 1:A:1 = AC-02 (CORE) 1:A:2 = AC-03 (CORE) 1:A:3 = AC-06 (1 CREDIT) 1:A:4 = QI-03 (CORE)	**AC-11 (Core):** Sets goals and monitors the percentage of patient visits with the selected clinician or team. **AC-02 (Core):** The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs. **AC-03 (Core):** The practice offers routine and urgent care appointments outside typical business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch. **AC-06 (1 Credit):** Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms. **QI-03 (Core):** Assesses performance on availability of major appointment types to

				meet patient needs and preferences for access.
	4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.	**PCMH 2: Team-Based Care, Element D: The Practice Team (MUST-PASS)** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 5 Training and assigning members of the care team to coordinate care for individual patients 6 Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7 Training and assigning members of the care team to	2:D:1-2 = TC-02 (CORE) 2:D:3 = TC-06 (CORE) 2:D:5-8 = NO EQUIVALENT	**TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions. **TC-06 (Core):** Has regular patient care team meetings or a structured communication process focused on individual patient care. (i.e. Huddles)

		manage the patient population 8 Holding regular team meetings addressing practice functioning		
Organized, Evidence-Based Care	**5a.** Use planned care according to patient need.	**PCMH 3: Population Health Management, Element E: Implement Evidence-Based Decision Support** The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder 2. A chronic medical condition 3. An acute condition 4. A condition related to unhealthy behaviors 5. Well child or adult care **PCMH 4: Care Management Support, Element A: Identify Patients for Care Management** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or	3:E:1, 2-6 = KM-20 (CORE) 4:A:1-5 = CM-01 (CORE) 4:A:6 = CM-02 (CORE) 4:B:1 = CM06 (1 CREDIT) 4:B:2 = CM-04 (CORE) 4:B:3 = CM-07 (1 CREDIT) 4:B:4 = CM-08 (1 CREDIT)	**KM-20 (Core):** Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria): A. Mental health condition, B. Substance use disorder, C. A chronic medical condition, D. An acute condition, E. A condition related to unhealthy behaviors, F. Well child or adult care, G. Overuse/appropriateness issues. **CM-01 (Core):** Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions, B. High cost/high utilization, C. Poorly controlled or complex conditions, D. Social determinants of health, E. Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff, patient/family/caregiver.

		patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria **PCMH 4: Care Management and Support, Element B: Care Planning and Self-Care Support (MUST PASS)** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in 1. Incorporating patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/caregiver	4:B:5 = CM-05 (CORE)	**CM-02 (Core):** Monitors the percentage of the total patient population identified through its process and criteria. **CM-04 (Core):** Establishes a person-centered care plan for patients identified for care management. **CM-06 (1 Credit):** Documents patient preference and functional/lifestyle goals in individuals care plans. **CM-07 (1 Credit):** Identifies and discusses potential barriers to meeting goals in individual care plans. **CM-08 (1 Credit):** Includes a self-management plan in individual care plans. **CM-05 (Core):** Provides a written care plan to the patient/family/caregiver for patients identified for care management.

	5b. Identify high risk patients and ensure they are receiving appropriate care and case management services.	**PCMH 4: Care Management Support, Element A: Identify Patients for Care Management** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria **PCMH 4: Care Management Support, Element B: Care Planning and Self-Care Support** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. The patient's care plan includes a self-management plan 5. Care plan is provided in writing to the patient/family/caregiver **Element C: Medication Management** The practice has a process for managing medications, and systematically implements the process in the following ways: 1. Reviews and reconciles medications for more than 50% of patients received from	4:A:1-5 = CM-01 (CORE) 4:A:6 = CM-02 (CORE) 4:B:1 = CM-06 (1 CREDIT) 4:B:2 = CM-04 (CORE) 4:B:3 = CM-07 (1 CREDIT) 4:B:4 = CM-08 (1 CREDIT) 4:B:5 = CM-05 (CORE) 4:C:1-2 = KM-14 (CORE) 4:C:3-4 = KM-16 (1 CREDIT) 4:C:6 = KM-15 (CORE) 2:B:5 = TC-09 (CORE)	**CM-01 (Core):** Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions, B. High cost/high utilization, C. Poorly controlled or complex conditions, D. Social determinants of health, E. Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff, patient/family/caregiver. **CM-02 (Core):** Monitors the percentage of the total patient population identified through its process and criteria. **CM-06 (1 Credit):** Documents patient preference and functional/lifestyle goals in individuals care plans. **CM-04 (Core):** Establishes a person-centered care plan for patients identified for care management. **CM-07 (1 Credit):** Identifies and discusses potential barriers to meeting goals in individual care plans. **CM-08 (1 Credit):** Includes a self-management plan in individual care plans. **CM-05 (Core):** Provides a written care plan to the patient/family/caregiver for patients identified for care management. **KM- 14 (Core):** Reviews and reconciles medications for more than 80 percent of

		care transitions 2. Reviews and reconciles medications with patients/families for more than 80% of patients of care transitions 3. Provides information about new prescriptions to more than 80% of patients/families/caregivers 4. Assesses understanding of medications for more than 50% of patients/families/caregivers, and dates the assessment 5. Assesses response to medications and barriers to adherence for more than 50% of patients, and dates the assessment 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50% of patients, and dates updates **PCMH 2: Team-Based Care, Element B: Medical Home Responsibilities** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 5 The scope of services available within the practice including how behavioral health needs are addressed		patients received from care transitions. **KM- 16 (1 Credit):** Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers. **KM-15 (Core):** Maintains an up-to-date list of medications for more than 80 percent of patients. This includes over-the-counter medications and herbal and vitamin/mineral/dietary (nutritional) supplements. **TC-09 (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.
	5c. Use point-of-care reminders based on clinical guidelines.	**PCMH 3: Population Health Management, Element E: Implement Evidence-Based Decision Support** The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder 2. A chronic medical condition 3. An acute condition 4. A condition related to unhealthy behaviors 5. Well child or adult care	3:E:1, 2-6 = KM-20 (CORE)	**KM-20 (Core):** Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria): A. Mental health condition, B. Substance use disorder, C. A chronic medical condition, D. An acute condition, E. A condition related to unhealthy behaviors, F. Well child or adult care, G. Overuse/appropriateness issues.

	5d. Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.	**PCMH 2: Team-Based Care,** **Element B: Medical Home Responsibilities** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 3 The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice 8 Instructions on transferring records to the practice, including a point of contact at the practice **Element D: The Practice Team (MUST-PASS)** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 7. Training and assigning members of the care team to manage the patient population **PCMH 3: Population Health Management,** **Element A: Patient Information (All factors)** **Element B: Clinical Data (All factors)** **Element C: Comprehensive Health Assessment (All factors)**	2:B:1-5 = TC-09 (CORE) 2:B:8 = NO EQUIVALENT 2:D:1 = TC-02 (CORE) 2:D3 = TC-06 (CORE) 2:D:4-8 = NO EQUIVALENT, SUPPORTS TC-02 3:A1-14 = NO EQUIVALENT 3:B:1 =KM-01 (CORE) 3:B:2-8, 10, 11 = NO EQUIVALENT 3:B:9 = KM-15 (CORE) 3:C:1 = NO EQUIVALENT 3:C:2-8 = KM-02 (CORE) 3:C:9 = KM-03 (CORE)	**TC-09 (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. **TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions. **TC-06 (Core):** Has regular patient care team meetings or a structured communication process focused on individual patient care. (i.e. Huddles) **KM-01 (Core):** Documents an up-to-date problem list for each patient with current and active diagnoses. **KM-15 (Core):** Maintains and up-to-date list of medications for more than 80 percent of patients. **KM-02 (Core):** Comprehensive health assessment includes A-I items (all items required). **KM-03 (Core):** Conducts depression screenings for adults and adolescents using a standardized tool. **KM-11B (1 CREDIT):** Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrates at least 2) b. Address health literacy of the practice

			3:C:10 = KM-11B (1 CREDIT)	

Patient-Centered interactions	**6a**. Respect patient and family values and expressed needs.	**PCMH 2: Team-Based Care,** **Element C: Culturally and Linguistically Appropriate Services** The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support (MUST PASS)** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in 1. Incorporating patient preferences and functional/lifestyle goals **Element E: Support Self-Care and Shared Decision Making** The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice: 4 Adopts shared decision making aids	2:C:1 = KM-09 (CORE) 2:C:2 = KM-10 (CORE) 2:C:3-4 = NO EQUIVALENT 4:B:1 = CM-06 (1 CREDIT) 4:E:4 = KM-24 (1 CREDIT)	**KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population. **KM-10 (Core):** Assesses the language needs of its population. **CM-06 (1 Credit):** Documents patient preference and functional/lifestyle goals in individuals care plans. **KM-24 (1 Credit):** Adopts shared decision-making aids for preference-sensitive conditions.

	6b. Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.	**PCMH 2: Team-Based Care, Element B:** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 4. The care team provides access to evidence-based care, patient/family education and self- management support **PCMH 4: Care Management and Support, Element B: Care Planning and Self-Care Support (MUST PASS)** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in 1. Incorporating patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/caregiver	2:B:1-5 = TC-09 (CORE) 4:B:1 = CM-06 (CORE) 4:B:2 = CM-04 (CORE) 4:B:3 = CM-07 (1 CREDIT) 4:B:4 = CM-08 (1 CREDIT) 4:B:5 = CM-05 (CORE)	**TC-09 (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. **CM-06 (1 Credit):** Documents patient preference and functional/lifestyle goals in individuals care plans. **CM-04 (Core):** Establishes a person-centered care plan for patients identified for care management. **CM-07 (1 Credit):** Identifies and discusses potential barriers to meeting goals in individual care plans. **CM-08 (1 Credit):** Includes a self-management plan in individual care plans. **CM-05 (Core):** Provides a written care plan to the patient/family/caregiver for patients identified for care management.

	6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.	**PCMH 2: Team-Based Care,** **Element C: Culturally and Linguistically Appropriate Services** The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population **Element D: The Practice Team** The practice uses a team to provide a range of patient care services by: 7. Training and assigning members of the care team to manage the patient population	2:C:1 = KM-09 (CORE) 2:C:2 = KM-10 (CORE) 2:C:3-4 = NO EQUIVALENT 2:D:7 = NO EQUIVALENT	**KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population. **KM-10 (Core):** Assesses the language needs of its population.
	6d. Provide self-management support at every visit through collaborative goal setting and patient action planning.	**PCMH 2: Team-Based Care,** **Element B:** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 4. The care team provides access to evidence-based care, patient/family education and self- management support **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals	2:B:4 = TC-09 (CORE) 4:B:1 = CM-06 (CORE) 4:B:2 = CM-04 (CORE) 4:B:3 = CM-07 (1 CREDIT) 4:B:4 = CM-08 (1 CREDIT) 4:B:5 = CM-05 (CORE) 4:E:1 = NO EQUIVALENT	**TC-09 (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. **CM-06 (1 Credit):** Documents patient preference and functional/lifestyle goals in individuals care plans. **CM-04 (Core):** Establishes a person-centered care plan for patients identified for care management. **CM-07 (1 Credit):** Identifies and discusses potential barriers to meeting goals in individual care plans. **CM-08 (1 Credit):** Includes a self-management plan in individual care plans.

		4. 4. Includes a self-management plan 5. Is provided in writing to the patient/family/caregiver **Element E: Support Self-Care and Shared Decision Making** The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice: 1. Uses an EHR to identify patient-specific education resources and provide them to more than 10% of patients 2. Provides educational materials and resources to patients 3. Provides self-management tools to record self-care results 4. Adopts shared decision making aids 5. Offers or refers patients to structured health education programs, such as group classes and peer support 6. Maintains a current resource list on 5 topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources	4:E:2,3,5 = KM-22 (1 CREDIT) 4:E:4 = KM-24 (1 CREDIT) 4:E:6 = KM-26 (1 CREDIT) 4:E:7 = KM-27 (1 CREDIT)	**CM-05 (Core):** Provides a written care plan to the patient/family/caregiver for patients identified for care management. **KM-22 (1 Credit):** Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs. **KM-24 (1 Credit):** Adopts shared decision-making aids for preference-sensitive conditions. **KM-26 (1 Credit):** Routinely maintains a current community resource list based on the needs identified in KM-21. **KM-27 (1 Credit):** Assesses the usefulness of identified community support resources.

	6e. Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.	**PCMH 2: Team-Based Care, Element D** The practice uses a team to provide a range of patient care services by: 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council **PCMH 6: Performance Measurement and Quality Improvement, Element C: Measure Patient/Family Experience** At least annually, the practice obtains feedback from patients/families on their experiences with the practice and there are. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least 3 of the following categories: • Access • Communication • Coordination • Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS Clinician and Group Survey Tool 3. The practice obtains feedback on the experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means	2:D:10 = QI-17 (2 credits) 6:C:1 = QI-04A (Core) 6:C:2 = QI-06 (1 credit) 6:C:3 = QI-07 (2 credits) 6:C:4 = QI-04 B (Core)	**QI-17 (2 Credits):** Involves patient/family/caregiver in quality improvement activities. **QI-04 (Core):** Monitors patient experience through: A. Quantitative data. Conducts a survey to evaluate patient/family/caregiver experiences across at least three dimensions such as Access, Communication, Coordination, Whole-person care, self-management support and comprehensiveness. B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means. **QI-06 (1 Credit):** The practice uses a standardized, validated patient experience survey tool with benchmarking data available. **QI-07 (2 Credits):** The practice obtains feedback on experiences of vulnerable patient groups.

ENHANCED ACCESS	**7a**. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email or in-person visits.	**PCMH 1: Patient-Centered Access,** **Element A: Patient-Centered Appointment Access (MUST PASS)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting to identify opportunities to improve access **Element B: 24/7 Access to Clinical Advice** The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on: 1. Providing continuity of medical record information for care and advice when office is closed 2. Providing timely clinical advice by telephone 3. Providing timely clinical advice using a secure, interactive electronic system **Element C: Electronic Access** The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system 1. More than 50% of patients have online access to their health information within 4 business days of when the information is available to the practice 2. More than 5% of patients view, and are provided the capability to download, their health information to a third party 4. A secured message was sent to more than 5% of	1:A:1 = AC-02 (CORE) 1:A:2 = AC-03 (CORE) 1:A:3 = AC-06 (1 CREDIT) 1:A:4 = QI-03 (CORE) 1:A:5 = NO EQUIVALENT 1:A:6 = QI-10 (CORE) 1:B:1=AC-12 (2 CREDITS) 1:B:2=AC-04 (CORE) 1:B:3=AC-08 (1 CREDIT) 1:C:1-4= NO EQUIVALENT 1:C:5= AC-08 (1 CREDIT) 1:C:6=AC-07 (1 CREDIT) 2:B:2= TC-09	**AC-02 (Core):** The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs. **AC-03 (Core):** The practice offers routine and urgent care appointments outside typical business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch. **AC-06 (1 Credit):** Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms. **QI-03 (Core):** Assesses performance on availability of major appointment types to meet patient needs and preferences for access. **QI-10 (Core):** Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences. **AC-12 (2 Credits):** Provides continuity of medical record information for care and advice when the office is closed. **AC-04 (Core):** Provides timely clinical advice by telephone. **AC-08 (1 Credit):** Has a secure electronic system for two-way communication to provide timely clinical advice.

		patients 5. Patients have two-way communication with the practice 6. Patients can request appointments, prescription refills, referrals and test results **PCMH 2: Team-Based Care, Element B: Medical Home Responsibilities** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed	(CORE)	**AC-07 (1 Credit):** Has a secure electronic system for patients to request appointments, prescription refills, referrals, and test results. **TC-09 (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.

	7b. Provide scheduling options that are patient- and family-centered and accessible to all patients.	**PCMH 1: Patient-Centered Access, Element A: Patient-Centered Appointment Access (MUST PASS)** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters **Element C: Electronic Access** The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system 1. A secured message was sent to more than 5% of patients 2. Patients have two-way communication with the practice 3. Patients can request for appointments, prescription refills, referrals and test results **PCMH 2: Team-Based Care,** **Element B: Medical Home Responsibilities** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 6. The practice provides equal access to all of their patients regardless of source of payment	1:A:1 = AC-02 (CORE) 1:A:2 = AC-03 (CORE) 1:A:3 = AC-06 (1 CREDIT) 1:C:1-4 = NO EQUIVALENT 2:B:6 = NO EQUIVALENT	**AC-02 (Core):** The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs. **AC-03 (Core):** The practice offers routine and urgent care appointments outside typical business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch. **AC-06 (1 Credit):** Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.

	7c. Help patients attain and understand health insurance coverage.	**PCMH 2: Team-Based Care, Element A: Continuity** The practice provides continuity of care for patients/families by: 3. Having a process to orient new patient to the practice **PCMH 2: Team-Based Care, Element B: Medical Home Responsibilities** The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information: 6. The practice provides equal access to all of their patients regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage	2:A:3 = TC-09 (CORE) 2:B:6-8 = NO EQUIVALENT	**TC-09 (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.
CARE COORDINATION	**8a**. Link patients with community resources to facilitate referrals and respond to social service needs.	**PCMH 4: Care Management and Support, Element E: Support Self-Care and Shared Decision Making** The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice: 5. Offers or refers patients to structured health education programs, such as group classes and peer support 6. Maintains a current resource list on 5 topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources	4:E:5 = KM-22 (1 CREDIT) 4:E:6 = KM-26 (1 CREDIT) 4:E:7 = KM-27 (1 CREDIT)	**KM-22 (1 Credit):** Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs. **KM-26 (1 Credit):** Routinely maintains a current community resource list based on the needs identified in KM-21. **KM-27 (1 Credit):** Assesses the usefulness of identified community support resources.

	8b. Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.	**PCMH 5: Track and Coordinate Care, Element B: Referral Tracking and Follow-up** **(MUST PASS)** The practice: 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals 9. Documents co-management arrangements in the patient's medical record 10. Asks patents/families about self-referrals and requesting reports from clinicians	5:B:1 = CC-07 (2 CREDITS) 5:B:2 = CC-08 (1 CREDIT) 5:B:3 = CC-09 (2 CREDITS) 5:B:4 = CC-10 (2 CREDITS) 5:B:5-6 = CC-04 (CORE) 5:B:7 = CC-21C (1 OF 3 CREDITS) 5:B:9 = CC-12 (1 CREDIT) 5:B:10 = NO EQUIVALENT	**CC-07 (2 Credits):** Considers available performance information on consultants/specialists when making referrals. **CC-08 (1 Credit):** Works with non-behavioral healthcare specialist to whom the practice frequently refers to set expectations for information sharing and patient care. **CC-09 (2 Credits):** Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care. **CC-10 (2 Credits):** Integrates behavioral healthcare providers into the care delivery system of the practice site. **CC-04 (Core):** The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical questions, the required timing and the type of referral, B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan, C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. **Related to CC-21** (Maximum 3 Credits): Demonstrates electronic exchange of information with external entities, agencies and registries. **CC-12 (1 Credit):** Documents co-management arrangements in the patient's medical record.

	8c. Track and support patients when they obtain services outside the practice.	**PCMH 2: Team-Based Care, Element B: The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:** 1. The practice is responsible for coordinating patient care across multiple settings 3. The practice functions most effectively as medical home if patients provide a complete medical history and information about care obtained outside the practice 8. Instructions on transferring records to the practice, including a point of contact at the practice **PCMH 5: Track and Coordinate Care, Element B: Referral Tracking and Follow-up** **(MUST PASS)** The practice: 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals	2:B:1-5 = TC-09 (CORE) 2:B:8 - NO EQUIVALENT 5:B:1 = CC-07 (2 CREDITS) 5:B:2 = CC-08 (1 CREDIT) 5:B:3 = CC-09 (2 CREDITS) 5:B:4 = CC-10 (2 CREDITS) 5:B:5-6, 8 = CC-04 (CORE) 5:B:7 = CC-21C (1 OF 3 CREDITS) 5:B:9 = CC-12 (1 CREDIT) 5:B:10 = NO EQUIVALENT	**TC-09 (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. **CC-07 (2 Credits):** Considers available performance information on consultants/specialists when making referrals. **CC-08 (1 Credit):** Works with non-behavioral healthcare specialist to whom the practice frequently refers to set expectations for information sharing and patient care. **CC-09 (2 Credits):** Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care. **CC-10 (2 Credits):** Integrates behavioral healthcare providers into the care delivery system of the practice site. **CC-04 (Core):** The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical questions, the required timing and the type of referral, B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan, C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. **Related to CC-21 (Maximum 3 Credits):** Demonstrates electronic exchange of

		8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports 9. Documents co-management arrangements in the patient's medical record 10. Asks patents/families about self-referrals and requesting reports from clinicians		information with external entities, agencies and registries. **CC-12 (1 Credit):** Documents co-management arrangements in the patient's medical record.
	8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.	**PCMH 5: Care Coordination and Care Transitions, Element C: Coordinate Care Transitions** The practice: 1. Proactively identifies patients with unplanned hospital admissions and ED visits 2. Shares clinical information with admitting hospitals and ED's 3. Consistently obtains patient discharge summaries from the hospital and other facilities 4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit 5. Exchanges patient information with the hospital during a patient's hospitalization 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50% of patient transitions of care	5:C:1 = CC-14 (CORE) 5:C:2 = CC-15 (CORE) 5:C:3 = CC-19 (1 CREDIT) 5:C:4 = CC-16 (CORE) 5:C:5 = CC-18 (1 CREDIT) 5:C;6 = NO EQUIVALENT 5:C:7 = CC-21C (1 OF 3 CREDITS)	**CC-14 (Core):** Systematically identifies patients with unplanned hospital admissions and emergency department visits. **CC-15 (Core):** Shares clinical information with admitting hospitals and emergency departments. **CC-19 (1 Credit):** Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities. **CC-16 (Core):** Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit. **CC-18 (1 Credit):** Exchanges patient information with the hospital during a patient's hospitalization. **CC-21 (Maximum Credits):** (C) Making the summary of care record accessible to another provider or care facility for care transitions.

	8e. Communicate test results and care plans to patients/families.	**PCMH 1: Patient-Centered Access, Element C: Electronic Access** The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system. 1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice 2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party 3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits	1:C:1-4 = NO EQUIVALENT	