

**Physician Practice Connections[®] -
Patient-Centered Medical Home
(PPC-PCMH) version
Standards**

PPC 1: Access and Communication

9 points

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Intent

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

Element A: Access and Communication Processes (must pass)

4 points

The practice establishes in writing standards for the following processes to support patient access:	Yes	No	NA
1. scheduling each patient with a personal clinician for continuity of care	<input type="checkbox"/>	<input type="checkbox"/>	
2. coordinating visits with multiple clinicians and/or diagnostic tests during one trip	<input type="checkbox"/>	<input type="checkbox"/>	
3. determining through triage how soon a patient needs to be seen	<input type="checkbox"/>	<input type="checkbox"/>	
4. maintaining the capacity to schedule patients the same day they call	<input type="checkbox"/>	<input type="checkbox"/>	
5. scheduling same day appointments based on practice's triage of patients' conditions	<input type="checkbox"/>	<input type="checkbox"/>	
6. scheduling same day appointments based on patient's/family's requests	<input type="checkbox"/>	<input type="checkbox"/>	
7. providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time	<input type="checkbox"/>	<input type="checkbox"/>	
8. providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week	<input type="checkbox"/>	<input type="checkbox"/>	
9. providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time	<input type="checkbox"/>	<input type="checkbox"/>	
10. providing an interactive practice Web site	<input type="checkbox"/>	<input type="checkbox"/>	
11. making language services available for patients/families with limited English proficiency.	<input type="checkbox"/>	<input type="checkbox"/>	
12. identifying health insurance resources for patients without insurance	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring

100%	75%	50%	25%	0%
Practice has written process for 9-12 items	Practice has written process for 7-8 items	Practice has written process for 4-6 items	Practice has written process for 2-3 items	Practice has written process for 0-1 items

Data source Documented process, Reports

Scope of review ONCE--NCQA scores this element once for the organization.

- Explanation** **IT Required:** Basic
Condition Specific: No
Details: The practice should have standards for staff to respond to requests during office hours as well as to urgent concerns after hours. The following points apply to particular items:
- Item 2—The goal is to minimize trips for the patient/family and as much as possible provide one-stop shopping
 - Item 7—Staff return patient calls within a time frame specified by the practice's policies
 - Item 8—A phone message that only directs patients to the emergency room after hours does not meet the standard
 - Items 9 and 10—Some practices use secure e-mail or an interactive Web site, either attached to the practice or from an external organization, for making appointments, communicating test results, renewing prescriptions or other non-urgent needs.
 - Item 11—Where applicable, practices should utilize interpretation services.
- Examples** **Data Source:** Written procedures for staff for appointments, triage and patient/family communication; log or schedule to demonstrate capacity (item 3).

Element B: Access and Communication Results (must pass) 5 points

The practice's data shows that it meets access and communication standards in 1A:	Yes	No	NA
1. visits with assigned personal clinician for each patient	<input type="checkbox"/>	<input type="checkbox"/>	
2. appointments scheduled to meet the standards in items 2-6 in 1A	<input type="checkbox"/>	<input type="checkbox"/>	
3. response times to meet standards for timely response to telephone requests	<input type="checkbox"/>	<input type="checkbox"/>	
4. response times to meet its standards for timely response to e-mail and interactive Web requests	<input type="checkbox"/>	<input type="checkbox"/>	
5. language services for patients with limited English proficiency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice's data meets 5 items	Practice's data meets 4 items	Practice's data meets 3 items	Practice's data meets 2 items	Practice's data meets 0-1 items

- Data source** Reports
- Scope of review** ONCE--NCQA scores this element once for the organization.
- Explanation** **IT Required:** Basic - Intermediate
Condition Specific: No
Details: The tracking reports should show that the practice meets its own standards for access through appointments, telephone calls, and e-mail or interactive Web site where applicable.
 The practice can do spot checks for these items, such as monitoring appointment wait times and telephone response times for a week to determine how well it meets standards.

For Item 4 the practice may exclude patients who do not have e-mail.

The practice may respond "not applicable" (NA) to item 5 if its patient population does not require language services.

Examples

Data Source: Tracking reports, either paper or screen shots, showing records for a period of appointments with personal clinicians, average wait for appointments, average time for returning telephone calls and emails.

PPC 2: Patient Tracking and Registry Functions

21 points

The practice systematically manages patient information and uses the information for population management to support patient care.

Intent

The practice has readily accessible, clinically useful information on patients that enables it to treat patients comprehensively and systematically.

Element A: Basic System for Managing Patient Data

2 points

The practice uses an electronic data system for patients that includes the following searchable patient information:	Yes	No
1. name	<input type="checkbox"/>	<input type="checkbox"/>
2. date of birth	<input type="checkbox"/>	<input type="checkbox"/>
3. gender	<input type="checkbox"/>	<input type="checkbox"/>
4. marital status	<input type="checkbox"/>	<input type="checkbox"/>
5. language preference	<input type="checkbox"/>	<input type="checkbox"/>
6. voluntarily self-identified race/ethnicity	<input type="checkbox"/>	<input type="checkbox"/>
7. address	<input type="checkbox"/>	<input type="checkbox"/>
8. telephone (primary contact number)	<input type="checkbox"/>	<input type="checkbox"/>
9. e-mail address (or “none” for patient)	<input type="checkbox"/>	<input type="checkbox"/>
10. internal ID	<input type="checkbox"/>	<input type="checkbox"/>
11. external ID	<input type="checkbox"/>	<input type="checkbox"/>
12. emergency contact information	<input type="checkbox"/>	<input type="checkbox"/>
13. current and past diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
14. dates of previous clinical visits	<input type="checkbox"/>	<input type="checkbox"/>
15. billing codes for services	<input type="checkbox"/>	<input type="checkbox"/>
16. legal guardian	<input type="checkbox"/>	<input type="checkbox"/>
17. health insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>
18. patient/family preferred method of communication.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	12-18 items were entered for 75-100% of patients	8-11 items were entered for 75-100% of patients	6-7 items were entered for 75-100% of patients	4-5 items were entered for 75-100% of patients	0-3 items were entered for 75-100% of patients

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation IT Required: Basic

Condition Specific: No

Details: A practice management system or registry may enable the practice to meet this

element; an EHR or more sophisticated system should include this basic data also. This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice should query its electronic registry, practice management system or other electronic system(s) to obtain data as follows:

- Denominator = total number of patients seen by the practice at least once in the last three months
- Numerator = number of those patients for whom each item is entered.

The report should show how many items are entered for 75 percent to 100 percent of patients.

Examples **Data Source:** Reports from electronic systems.

Element B: Electronic System for Clinical Data **3 points**

The practice’s clinical data system or systems to manage care of patients include the following clinical patient information in searchable data fields:	Yes	No
1. status of age-appropriate preventive services (immunizations, screenings, counseling)	<input type="checkbox"/>	<input type="checkbox"/>
2. allergies and adverse reactions	<input type="checkbox"/>	<input type="checkbox"/>
3. blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
4. height	<input type="checkbox"/>	<input type="checkbox"/>
5. weight	<input type="checkbox"/>	<input type="checkbox"/>
6. head circumference for patients 2 years or younger		
7. body mass index (BMI) calculated	<input type="checkbox"/>	<input type="checkbox"/>
8. laboratory test results	<input type="checkbox"/>	<input type="checkbox"/>
9. presence of imaging results	<input type="checkbox"/>	<input type="checkbox"/>
10. presence of pathology reports	<input type="checkbox"/>	<input type="checkbox"/>
11. presence of advance directives.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	System has 9-11 data fields	System has 7-8 data fields	System has 5-6 data fields	System has 3-4 data fields	System has 0-2 data fields

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate
Source of Content: IOM EHR Letter Report
Condition-Specific: No

Details: For this element, the system may be a registry, electronic health record or combination of systems. The practice uses its systems for internally generated clinical data. All items should be kept in searchable form; for items 8–10, data may indicate the presence of a written report not in the system. For children under age 18, item 7 is BMI percentile. For children under age 18, practice can enter “NA” in the clinical data system. After BMI is calculated for children and teens, the BMI number is plotted on the

CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States.

Head Circumference in children under 2 years of age is a vital growth parameter that provides a sensitive guide to the child's: health, development, nutritional status and response to treatment.

Examples **Data Source:** Screen shots or reports showing fields in patient records. Where applicable, these fields may show that the patient has no allergies or lab or imaging tests.

Element C: Use of Electronic Clinical Data **3 points**

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

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75-100% of patients seen in the past 3 months have at least 7 fields completed	50-74% of patients seen in the past 3 months have at least 7 fields completed	25-49% of patients seen in the past 3 months have at least 7 fields completed	10-24% of patients seen in the past 3 months have at least 7 fields completed	Less than 10% of patients seen in the past 3 months have at least 7 fields completed

Data source Records or files

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate

Source of Content: IOM

Condition-specific: No

Details: This element calls for calculation of a percentage that generally requires a numerator and a denominator. The practice should query its electronic registry, practice management system or other electronic systems to obtain data as follows:

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom at least seven fields are entered.

The report must show the percent of patients seen in the last three months for whom the practice has entered at least seven of the items in 2B.

If the system has capability to store items in data fields but the practice does not use it, the practice may receive an override score of 25% credit.

Examples **Data source:** Reports from electronic system.

Element D: Organizing Clinical Data (must pass) **6 points**

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

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

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75-100% of records of patients seen in the past 3 months include at least 3 tools with information documented	50-74% of records of patients seen in the past 3 months include at least 3 tools with information documented	25-49% of records of patients seen in the past 3 months include at least 3 tools with information documented	10-24% records of patients seen in the past 3 months include at least 3 tools with information documented	Less than 10% of patient records include at least 3 tools

Data source Records or files

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT Required:** Basic

Source of Content: IOM I Letter Report

Condition-specific: No

Details: Use of charting tools encourages clinicians to be consistent when they document patient information and findings. This element measures the degree of use of a systematic process that does not rely on the clinicians’ memory to document certain clinical information—the paper or electronic tool prompts them to do so. Further, the charting tools require a response to each item, prompting the clinician to note either the presence of problems, prescribed medications and risk factors or that the patient has none.

Item 4, age-appropriate risk factor assessments, should come from evidence-based guidelines. Examples are:

- use of tobacco for age 12 and over
- cognitive assessment for new patients over 75
- use of alcohol for age 15 and over
- risk of falls for the elderly
- secondhand smoke
- use of seat belts
- use of bike helmets.

Item 4 requires the practice to record assessment findings for three age-appropriate risk factors (i.e., smoking—no history, alcohol—1 beer per day, weight—170lbs, height—5’1”). The practice should show it documents assessment of age-appropriate risk factors in its electronic system or paper flow sheet, questionnaire or checklist at every

appropriate visit. Age-appropriate risk factors may include, but are not limited to, mental health concerns, tobacco use, substance abuse, obesity, at-risk sexual behavior, violence, dementia or family history of cancer or diabetes.

Item 5 requires the practice to use a standard format for progress notes, paper or electronic.

Item 6:

Early intervention services for children from birth to 3 years of age and early childhood education services for children 3-5 years of age are widely available for children with developmental delays or disabilities in the United States. Early identification of children with developmental delays is vital in the primary care setting.

Examples of parent report instruments: Parents Evaluation of Developmental Status, Ages and Stages Questionnaires, Child Development Inventories.

Examples of instruments that involve direct examination of the child's skills: Denver II screening test, Bayley Infant Neurodevelopmental Screener, Battelle Developmental Inventory, Early Language Milestone Scale, Brigance Screens.

Item 7:

Growth measurements encompass the measurement of height, weight, head circumference and Body Mass Index. These measurements are plotted against the age of the child in standardized universal growth charts (CDC growth charts).

CDC growth charts assess physical growth in children and adolescents. Using these charts, health care providers can compare growth in infants, children and adolescents with a nationally representative reference based on children of all ages and racial or ethnic groups. Comparing body measurements with the appropriate age- and gender-specific growth chart enables health care providers to monitor growth and identify potential health- or nutrition-related problems.

This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

Method 1 — Query the practice's electronic registry, practice management

system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom three tools have information entered.

Method 2 — Review a sample of medical records using the sample method in NCQA's Record Review Worksheet.

Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see element 2E):

- Denominator = the sample of patient medical records using NCQA's sampling method in the Record Review Worksheet.
- Numerator = the patients from the medical record review for whom three tools are completed.

To receive credit the practice must show the percentage of patients seen in the past

three months for whom the practice has documented information in the charting tools.

Examples

Data source: Medical record review.

Charting tools in the medical record may be paper-based or electronic templates or paper-based flow sheets. An EHR or a paper-based flow sheet may include several of the tools listed.

Element E: Identifying Important Conditions (must pass) 4 points

The practice uses an electronic or paper-based system to identify the following diagnoses and conditions:	Yes	No
1. practice’s most frequently seen diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
2. most important risk factors in the practice’s patient population	<input type="checkbox"/>	<input type="checkbox"/>
3. three conditions that are clinically important in the practice’s patient population.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice identifies 3 items	Practice identifies 2 items	Practice identifies 1 item	No scoring option	Practice identifies 0 items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT Required:** Basic
Condition-specific: No

Details: This element requires the practice to use data for population management, producing reports on most frequently seen conditions and risk factors, and determining three conditions on which it concentrates care management. To determine the clinically important conditions, the practice analyzes its entire population. To identify the most important risk factors in the practice’s population, the practice uses community-based demographic characteristics of its patients and identifies the risks generally associated with these demographic characteristics, e.g. poverty.

In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

The most frequently seen diagnoses are those that the practice sees most often and may include single episode conditions, such as colds or urinary tract infections, or chronic conditions. The clinically important conditions are chronic or recurring conditions that the practice sees such as otitis media, asthma, diabetes or congestive heart failure. In some cases, the most frequently seen conditions may be the same as the clinically important conditions.

The practice can use any of the following criteria to identify the most frequently seen diagnoses, the most important risk factors and the three important conditions:

- Number of patients with the conditions, problems or risk factors
- Number of visits for the conditions or problems

- Total fees billed or other measures of cost associated with the conditions or problems, or risk factors

In addition, the practice can also use the following criteria to identify the three important conditions:

- Ability to treat or change the conditions or problems (how amenable the conditions are to care management; whether clinical guidelines are available)
- Other evidence such as conditions for which the practice is measuring performance or receiving rewards for performance; conditions that the practice has selected or targeted to improve performance.

To identify the most important risk factors in the practice’s population, the practice uses the demographic characteristics of its patients and identifies the risk factors generally associated with those demographic characteristics. Alternatively the practice may analyze the presence or absence of those risk factors in its own patient population.

Examples **Data Source:** Reports

Element F: Use of System for Population Management **3 points**

The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, as follows:	Yes	No
1. patients needing pre-visit planning (obtaining tests prior to visit, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
2. patients needing clinician review or action	<input type="checkbox"/>	<input type="checkbox"/>
3. patients on a particular medication	<input type="checkbox"/>	<input type="checkbox"/>
4. patients needing reminders for preventive care	<input type="checkbox"/>	<input type="checkbox"/>
5. patients needing reminders for specific tests	<input type="checkbox"/>	<input type="checkbox"/>
6. patients needing reminders for follow-up visits such as for a chronic condition	<input type="checkbox"/>	<input type="checkbox"/>
7. patients who might benefit from care management support.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses information to take action on 5-7 items	Practice uses information to take action on 3-4 items	Practice uses information to take action on 1-2 items	No scoring option	Practice does not use information to take action

Data source Reports

Scope of review

Explanation **IT Required:** Intermediate

Condition-specific: No

Details: The electronic system provides practice-wide reports on any of the following fields: demographic information, contact information such as zip codes, imaging tests, laboratory tests, prescription medications, over-the-counter medications, diagnosis or treatment codes, status of preventive health services, risk factors. The practice uses information from the reports to manage specific populations of patients (e.g., patients with diabetes).

The practice also shows how it uses the reports to remind patients/families of needed services. The practice reminds patients/families by mail, telephone or electronic mail when services are due. For instance, in addition to the report showing the number of patients eligible for mammograms, the practice provides evidence or a brief statement describing how it reminds those patients to get mammograms.

Some examples of the population management function would be these or similar items:

- Identify all patients who are taking a medication for which the practice received a warning.
- Identify all patients with ischemic vascular disease not taking appropriate medication.
- Identify all children with developmental delay.
- Identify all children and adolescents diagnosed with asthma.
- Identify all women over 50 who are due for a mammogram.
- Identify all adult patients with elevated LDL for whom appropriate medication has not been prescribed.
- Identify all diabetic patients whose HbA1c is over 9.
- Identify all patients with blood pressure greater than 140/90.

The practice's system needs to link the decision rules to the relevant patient-specific data, such as demographics, age, ICD diagnosis codes, CPT procedure codes, test results, medication and clinical data (blood pressure, weight or BMI smoking status, etc.).

If the system has the capability to generate lists but has not used it, the practice may receive an override score of 20 percent.

Examples

Data Source: The practice provides computerized reports or screen shots and one of the following two options showing use of information in the reports:

- a written description of the process
- examples of use of the reports (see the bulleted list in the details).

PPC 3: Care Management

20 points

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patient’s care.

Intent

The practice maintains continuous relationships with patients by implementing evidence-based guidelines and applying them to the identified needs of individual patients over time and with the intensity needed by the patients.

Element A: Guidelines for Important Conditions (must pass) 3 points

	Yes	No
The practice adopts and implements evidence-based diagnosis and treatment guidelines for:		
1. first clinically important condition	<input type="checkbox"/>	<input type="checkbox"/>
2. second clinically important condition	<input type="checkbox"/>	<input type="checkbox"/>
3. third clinically important condition.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice implements guidelines for 3 conditions	No scoring option	Practice implements guidelines for 2 conditions	Practice implements guidelines for 1 condition	Practice does not implement guidelines for any conditions

Data source Materials

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT Required:** Basic
Condition-specific: Yes
Details: The physicians in the practice adopt evidence-based guidelines and use them. The practice’s guidelines must cover three clinically important conditions for its population. The practice’s workflow organizers ensure that the guidelines are meaningful to the clinicians in the practice and that they are consistent with the standards of care that the practice wants to follow.
 In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.
 Practices will need to use the same three clinically important conditions for Elements 2D, 2E, 3A, 3D, 4B and 9C.
 When identifying the “first clinically important condition,” the “second clinically important condition” and the “third,” practices are not indicating any kind of hierarchy among the three.

Examples **Data Source:** Workflow organizers, which demonstrate both adoption and implementation of guidelines by the practice.

- Paper-based organizers—algorithms for developing treatment plans, flow sheets or templates for documenting progress.
- Electronic system organizers (registry, I or other system)—screenshots showing

templates for treatment plans and documenting progress.

Element B: Preventive Service Clinician Reminders **4 points**

The practice uses a paper-based or electronic system with guideline-based reminders for the following services when seeing the patient:	Yes	No	NA
1. age-appropriate screening tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. age-appropriate immunizations (e.g., influenza, pediatric)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. age-appropriate risk assessments (e.g., smoking, diet, depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. counseling (e.g., smoking cessation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses reminders for 4 items	Practice uses reminders for 3 items	Practice uses reminders for 2 items	Practice uses reminders for 1 item	Practice uses reminders for no items

Data source Reports

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation **IT Required:** Basic if paper-based system, intermediate if electronic system
Condition-specific: No
Details: This element requires using alerts and reminders across the practice for patients who need particular services. The practice identifies patients by age, gender and status of preventive services, and prompts the clinician at the point of care. The following are *examples* of types of alerts and reminders:

- Order mammogram
- Assess smoking status and give cessation advice or treatment. “Counseling” includes anticipatory guidance.
- Immunizations as per AAP/AAFP/CDC (ACIP) recommendations.

A practice could indicate that a factor is not applicable if the practice’s specialties are not involved with providing preventive services for patients. For example, some surgical specialties may not be involved with identifying and providing reminders for screening tests or age-appropriate immunizations.

Examples **Data Source Example:** Documentation from an electronic system may include reports or screen shots.

Documentation from a paper-based system may include templates, flow sheets, algorithms or reminders.

The practice must show that its clinicians have available decision support for interactions with patients including in-person appointments, telephone calls and e-mail communication.

Element C: Practice Organization **3 points**

The care team manages patient care in the following ways:	Yes	No
1. nonphysician staff remind patients of appointments and collect information prior to appointments	<input type="checkbox"/>	<input type="checkbox"/>

- 2. nonphysician staff execute standing orders for medication refills, order tests and deliver routine preventive services
- 3. nonphysician staff educate patients/families about managing conditions
- 4. nonphysician staff coordinate care with disease management or case management programs.

Scoring	100%	75%	50%	25%	0%
	Staff manage 4 items	Staff manage 3 items	Staff manage 2 items	No scoring option	Staff manage 0-1 items

Data source Materials

Scope of review ONCE—NCQA scores this element once for the organization.

Explanation IT Required: Basic

Condition-specific: No

Details: While physicians are responsible for directing and coordinating patient care, managing patient care is usually a team effort that involves all members of the practice who interact with patients (i.e., physicians, nurses, allied health personnel/care coordinator/family partner). The practice uses a team approach in managing patient care. Shared responsibilities are designed to maximize use of each team member’s level of training and expertise. In small practices, this may be designated roles for the physician, the nurse, and the administrative person if there is one. In most practices, the availability of nurse case managers will only be through the patients’ health plans or other large organization. In some practices physicians may handle significant patient care responsibilities, especially for complex patients.

Disease management or care management may be provided internally by the practice or group or available to the patient externally, usually through the health plan.

Examples **Data Source:** Job descriptions, protocols, standing orders.

Element D: Care Management for Important Conditions 5 points

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

- 1. conducting pre-visit planning with clinician reminders
- 2. writing individualized care plans
- 3. writing individualized treatment goals
- 4. assessing patient progress toward goals
- 5. reviewing medication lists with patients/families
- 6. reviewing self-monitoring results and incorporating them into the medical record at each visit
- 7. assessing barriers when patients have not met treatment goals
- 8. assessing barriers when patients have not filled, refilled or taken prescribed medications
- 9. following up when patients have not kept important appointments
- 10. reviewing longitudinal representation of patient’s historical or targeted clinical measurements

11. completing after-visit follow-up.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75% or more of patients seen in the past 3 months have at least 4 items documented	50-74% of patients seen in the past 3 months have at least 4 items documented	25-49% of patients seen in the past 3 months have at least 4 items documented	11-24% of patients seen in the past 3 months have at least 4 items documented	10% or fewer patients seen in the past 3 months have at least 4 items documented

Data source Records or files**Scope of review** ONCE--NCQA scores this element once for the organization.**Explanation** **IT Required:** Basic**Source of Content:** IOM**Condition-specific:** Yes

Details: This element is scored once, from a sample across all three important conditions. In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

Not all patients with important conditions require care management, and those that do require it can benefit from all of the actions called for in this element. The physician may decide that patients already achieving good outcomes do not require care management; in those cases, a notation that the patient has good outcomes would suffice in place of a record of the care management processes.

This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

Method 1 - Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom each item is entered.

Method 2 - Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see element 2E).

- Denominator = the sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = the patients from the medical record review for whom at least four items are entered

Written care plans (item 2) address the respective responsibilities of the medical home

and specialists to whom the practice has referred the patient. The barriers to be addressed (items 7–9) may include the patients’ lack of understanding, motivation, financial need, insurance issues or transportation problems.

Important appointments (item 9) are those that the practice has requested the patient to make in order to follow standards of care (e.g., follow-up visits for monitoring blood pressure or blood sugar levels). Examples of after-visit follow up (item 10) may include checking with patients to confirm they filled a prescription or received care with a consultant.

Examples of longitudinal of patient data (item 11) may include graphs or flow sheets showing blood pressure, weight or LDL levels over time.

Records may show that the practice performs these functions via phone, individual visits, group visits, e-mail or some combination of these. The practice may also utilize another organization, such as a disease management organization, to perform these functions.

Examples **Data Source:** Medical record showing the components of care management.

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

The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care:	Yes	No	NA
1. identifies patients who receive care in facilities	<input type="checkbox"/>	<input type="checkbox"/>	
2. systematically sends clinical information to the facilities with patients as soon as possible	<input type="checkbox"/>	<input type="checkbox"/>	
3. reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes	<input type="checkbox"/>	<input type="checkbox"/>	
4. contacts patients after discharge from facilities	<input type="checkbox"/>	<input type="checkbox"/>	
5. provides or coordinates follow-up care to patients/families who have been discharged	<input type="checkbox"/>	<input type="checkbox"/>	
6. coordinates care with external disease management or case management organizations, as appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. communicates with patients/families receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. communicates with case managers for patients receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. for patients transitioning to other care, develops a written transition plan in collaboration with the patient and family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Activities include 5-10 items	Activities include 3-4 items	Activities include 2 items	No scoring option	Activities include 0-1 items

Data source Reports

Scope of review	ONCE--NCQA scores this element once for the organization.
Explanation	<p>IT Required: Basic</p> <p>Condition-specific: No</p> <p>Details: When the need for facility care is anticipated, i.e. when not an emergency, the practice provides the facility with appropriate information. The practice or external organization reviews data to identify patients who receive inpatient or outpatient care at a facility. A facility may be a hospital, an emergency room, a skilled nursing facility or a surgical center. The practice does not wait for these patients to make an appointment, but contacts them directly. Proactive contact includes assisting patients with appropriate care to prevent worsening of their conditions. After the practice has contacted patients, it ensures they receive follow-up care as necessary. Examples of follow-up care include, but are not limited to, physician counseling, referrals to community resources, disease or case management or self-management support programs.</p> <p>When a patient requires disease management or case management due to frequent emergency room visits, frequent hospitalizations, clinically important conditions or other reason, the practice maintains continuity of care by regularly communicating with both the patient and the disease or case manager. The practice or external organization has a written protocol describing the schedule for communication and at least one example showing the frequency of communication between disease or case manager and patient and one example of disease or case manager and physician.</p> <p>Youth and family receive coordination and support to link their health and transition plans with other relevant adolescent and adult practitioners.</p>
Examples	<p>Data Source: May be from the practice itself or from an external case management organization such as a disease management organization with which the practice works. The data sources may include:</p> <ul style="list-style-type: none">• protocols that include the practice's timeframe for patient follow up after an admission or emergency room visit• protocols for using care plans and patient visit flow sheets• printout from registry, EHR, hospital emergency room, admitting department or other computerized reports that include a list of identified patients, emergency room visits and inpatient admissions• manual or electronic patient health/needs assessments• blinded case management or medical record notes.

PPC 4: Patient Self-Management Support

6 points

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

Intent

The practice collaborates with patients and families to pursue their goals for optimal achievable health.

Element A: Documenting Communication Needs

2 points

The practice assesses patient/family-specific barriers to communication using a systematic process to:	Yes	No
1. identify and display in the record the language preference of the patient and family	<input type="checkbox"/>	<input type="checkbox"/>
2. assess both hearing and vision barriers to communication.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice assesses 2 items	No scoring option	Practice assesses 1 item	No scoring option	Practice does not assess any items

Data source Documented process, Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation IT Required: Basic

Condition Specific: No

Details: For this element, the practice provides documentation of a systematic process for prompting clinicians to assess language preference and hearing and vision communication barriers. This element requires a systematic process that does not depend on practice staff remembering to assess the issues—the paper or electronic system prompts the practice's staff member to do so.

Examples **Data Source:** Documents that show how the practice records language preference (e.g., screen shots, patient assessment forms) and how the practice determines the percentage of its patients that prefer another language (e.g., reports from an electronic system, review of a sample of records).

Health literacy is a major barrier to quality care and is the subject of current NCQA research. The results of this research will inform future versions of PPC-PCMH.

Element B: Self-Management Support (must pass)

4 points

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

1. assesses patient/family preferences, readiness to change and self-management abilities
2. provides educational resources in the language or medium that the patient/family understands

- 3. provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients to record results in the home setting where applicable
- 4. provides or connects patients/families to self management support programs
- 5. provides or connects patients/families to classes or education programs
- 6. provides or connects patients/families to other self-management resources where needed
- 7. provides written care plan to the patient/family.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	25%	0%
	75%-100% of patients seen in the past 3 months have at least 3 activities documented	50%-74% of patients seen in the past 3 months have at least 3 activities documented	25%-49% of patients seen in the past 3 months have at least 3 activities documented	11%-24% of patients seen in the past 3 months have at least 3 activities documented	10% or less patients seen in the past 3 months have at least 3 activities documented

Data source Records or files

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Basic

Condition-Specific: No

Details: This element addresses the practice helping patients manage their health. This element goes beyond physician counseling or guidance during an office visit. The practice or its medical group may provide self-management programs or classes or it may refer to community resources, when needed and available.

Written materials for patients should be appropriate for patients with low levels of literacy (5th grade reading level).

This element calls for calculation of a percentage, which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

Method 1 - Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

- Denominator = total number of patients with one of the three clinically important conditions seen at least once by the practice in the last three months
- Numerator = number of those patients for whom each item is entered.

Method 2 - Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see element 2E).

- Denominator = the sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = the patients from the medical record review for whom at least three items are entered

Not all patients with important conditions require self-management support, and those that do require it can benefit from all of the actions called for in this element. The physician may decide that patients already achieving good outcomes do not require self-management support; in those cases, a notation that the patient has good outcomes would suffice in place of a record of the self-management items in this element.

Examples of item 1, assessing readiness to change, include questionnaires and self-assessment forms. Examples of item 4, self management programs, include weight loss and smoking cessation programs. Examples of item 5, classes taught by instructors, include diabetes and asthma education. Examples of item 7, other self management resources, include group visits, counseling and support groups.

Examples

Data Source: Medical record review includes:

- referrals to programs, classes or other self-management resources from the patient record
- use of tool for assessing patient preferences, readiness to change and self-management abilities
- use of educational brochures, pamphlets and video
- self-monitoring tool or personal health record
- referrals to community resources.

PPC 5: Electronic Prescribing**8 points**

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

Intent

The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions and by using drug safety checks and cost information when prescribing.

Element A: Electronic Prescription Writing**3 points**

The practice uses an electronic system to write prescriptions using either:

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

Select the choice that most closely reflects the practice's performance.

- 75-100% of new prescriptions for patients seen in the last 3 months written with item 2
- 75-100% of new prescriptions for patients seen in the last 3 months written with item 1
- Practice has system capable of doing either item 1 or item 2, but practice does not use
- System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Scoring

100%	75%	50%	25%	0%
75-100% of new prescriptions for patients seen in the last 3 months written with item 2	75-100% of new prescriptions for patients seen in the last 3 months written with item 1	No scoring option	Practice has system capable of doing either item 1 or item 2, but practice does not use	System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate

Source of Content: *Electronic Prescribing: Toward Maximum Value and Rapid Adoption, A Report of the Electronic Prescribing eHealth Initiative, April 14, 2004*

Condition Specific: No

Details: This element calls for calculation of a percentage that generally requires a numerator and a denominator. The practice may use one of the methods in element 2A to calculate the percentage.

The term **general** in all the prescribing elements refers to information about medications from standard data bases. The term **patient-specific** refers to information that is related or linked to data on a particular patient.

Examples **Data Source:** Reports from system.

Element B: Prescribing Decision Support—Safety

3 points

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

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

- Practice uses 8 or more kinds of alerts and information
- Practice uses 4 to 7 kinds of alerts and information
- Practice uses 2 to 3 kinds of alerts
- System has capability of providing 6 or more kinds of alerts, but practice does not use them
- No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

Scoring	100%	75%	50%	25%	0%
	Practice uses 8 or more kinds of alerts and information	Practice uses 4 to 7 kinds of alerts and information	Practice uses 2 to 3 kinds of alerts	System has capability of providing 6 or more kinds of alerts, but practice does not use them	No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Advanced if practice obtains patient-specific data on filled prescriptions, Intermediate for all general alerts and for patient-specific alerts using internal data on prescribed medications.

Source of Content: eHealth Initiative, US Pharmacopoeia

Condition Specific: No

Details: The practice’s electronic system should alert clinicians to specific prescribing

issues for patient safety.

Addressed by this element are:

- Standalone electronic prescription reference tools that provide **general** automatic alerts—these could meet the factors that call for general information
- Electronic prescription writers or EHRs that provide **general** automatic alerts—these could also meet the factors that call for **general** information
- Electronic prescription writers or EHRs that provide **patient-specific** drug and medication management information. These utilize a list of medications a patient is taking, as well as other patient-specific information to generate alerts. These tools should also generate alerts based on general information, as the clinician can not assume that all needed patient-specific information is available electronically in the practice’s system. Patients may have history, diagnoses or medications that the practice’s system has not captured.

NCQA has first-year HEDIS specifications for items 10 and 13. In the future, national organizations may provide more specifications to standardize some of these types of alerts. Systems should have the capability of adding specific alerts as specifications become available.

Examples **Data Source:** Reports from the system, paper or electronic, showing an example of use of each item.

Element C: Prescribing Decision Support—Efficiency **2 points**

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

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

Select the choice that most closely reflects the organization's performance.

- Practice uses 2 tools
- Practice uses 1 tool
- System has capability to support both options; practice does not use it
- System does not have capability or practice does not use either tool

Scoring	100%	75%	50%	25%	0%
	Practice uses 2 tools	Practice uses 1 tool	No scoring option	System has capability to support both options; practice does not use it	System does not have capability or practice does not use either tool

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Advanced if checks are patient-specific (requires connection to formulary); Intermediate if general checks.

Condition Specific: No

Details: The practice's electronic system should alert the clinician to the most cost-effective of the choices for the patient, including generic drugs. The most effective type of tool actually connects with or downloads the formulary for the patient's health plan, to alert the clinician to the most efficient choice for the patient.

Examples

Data Source: Reports from the system, screen shots, practice protocols.

PPC 6: Test Tracking

13 points

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

Intent

The practice works to improve effectiveness of care, patient safety and efficiency by using timely information on all tests and results.

Element A: Test Tracking and Follow Up (must pass)

7 points

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

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

Select the choice that most closely reflects the practice's performance.

- Practice does 4-6 types of tracking and follow-up
- Practice does 3 types of tracking and follow-up
- Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it
- Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Scoring	100%	75%	50%	25%	0%
	Practice does 4-6 types of tracking and follow-up	No scoring option	Practice does 3 types of tracking and follow-up	Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it	Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Basic if paper system, intermediate if electronic system within the office, advanced if interconnected with laboratory or radiology

Condition Specific: No

Details: Whether the system is manual or electronic, there must be evidence that the practice reviews and uses the log before or at the beginning of every patient

appointment. There must be evidence that the practice both follows up with the clinician and proactively notifies the patient of abnormal results; filing the report in the medical record for the next time the patient comes in does not meet the intent of the standard.

Examples **Data Source:** Reports or logs—may be a paper log or an electronic in-box showing outstanding tests and showing how the practice flags abnormal results.

Element B: Electronic System for Managing Tests **6 points**

The practice manages tests with an electronic system to:	Yes	No
1. order lab tests	<input type="checkbox"/>	<input type="checkbox"/>
2. order imaging tests	<input type="checkbox"/>	<input type="checkbox"/>
3. retrieve lab results directly from source	<input type="checkbox"/>	<input type="checkbox"/>
4. retrieve imaging text reports directly from source	<input type="checkbox"/>	<input type="checkbox"/>
5. retrieve images directly from the source	<input type="checkbox"/>	<input type="checkbox"/>
6. route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison	<input type="checkbox"/>	<input type="checkbox"/>
7. flag duplicate tests ordered	<input type="checkbox"/>	<input type="checkbox"/>
8. generate alerts for appropriateness of tests ordered.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses 5-8 functions	Practice uses 3-4 functions	Practice uses 1-2 functions	No scoring option	Practice does not use system

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Advanced
Condition Specific: No

Details: This element assumes electronic communication between the practice and the lab and imaging facilities, as well as electronic alerts generated by or for the practice. If the practice has electronic capability to manage tests but has not used it, it may receive an override score of 25 percent.

Internet communication with labs qualifies as an electronic system.

Examples **Data Source:** Reports or screen shots from the system showing examples of each of the functions.

PPC 7: Referral Tracking

4 points

The practice systematically documents and tracks referrals and referral results.

Intent

The practice seeks to improve effectiveness, timeliness and coordination of care by following through on consultations with other practitioners.

Element A: Referral Tracking (must pass)

4 points

Outside of paper medical records and patient visits, the practice uses a paper-based or electronic system to assist in tracking practitioner referrals designated as critical until the specialist or consultant report returns to the practice. The practice uses a system that includes the following information for its referrals:

Yes No

- | | | |
|----------------------------|--------------------------|--------------------------|
| 1. origination | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. clinical details | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. tracking status | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. administrative details. | <input type="checkbox"/> | <input type="checkbox"/> |

Scoring

100%	75%	50%	25%	0%
Practice uses system that includes all 4 items	Practice uses system that includes 2-3 items	Practice uses system that includes 1 item	No scoring option	System does not include any of the items

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Basic or advanced. (Basic for paper system; advanced for electronic system).

Source of Content: HL-7 Functional standards **Condition Specific:** No

Details: Origination includes the referring clinician (the origin of the referral).

Clinical details include the clinical reason for requesting the referral as well as relevant clinical information. This may include:

- reason for the consultation
- pertinent clinical findings
- support person
- functional status
- family history
- social history
- plan of care
- health care providers

Administrative details include insurance information, including whether the referral requires health plan approval.

Tracking status includes whether or not the consultant report has returned to the practice.

A critical referral is determined by the physician to be important to the treatment of the patient or indicated by practice guidelines. An example would be a referral to a breast surgeon for examination of a possibly cancerous lump or a referral to a mental health professional for a patient identified with depression or suicidal ideation.

As many patients with special health care needs receive care regularly from a specialist or consultant, it is essential that the practice remain engaged in that care. The practice should establish an effective mechanism of timely communication with the specialist or consultant either by phone, fax or e-mail in addition to written correspondence.

Examples

Data Source: Written logs or other paper-based documents if not electronic, reports from the system if electronic.

PPC 8: Performance Reporting and Improvement

15 points

The practice regularly measures its performance and takes actions to continuously improve.

Intent

The practice seeks to improve effectiveness, efficiency, timeliness and other aspects of quality by measuring and reporting performance, comparing itself to national benchmarks, giving physicians regular feedback and taking actions to improve.

Element A: Measures of Performance (must pass)

3 points

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

	Yes	No
1. clinical process (e.g., percentage of women 50+ with mammograms or childhood vaccination rates)	<input type="checkbox"/>	<input type="checkbox"/>
2. clinical outcomes (e.g., HbA1c levels for diabetics)	<input type="checkbox"/>	<input type="checkbox"/>
3. service data (e.g., backlogs or wait times)	<input type="checkbox"/>	<input type="checkbox"/>
4. patient safety issues (e.g., medication errors).	<input type="checkbox"/>	<input type="checkbox"/>

Scoring

	100%	75%	50%	25%	0%
	Practice measures at least 2 types of performance	No scoring option	Practice measures 1 type of performance	No scoring option	No areas of performance measured

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation IT Required: Basic

Condition Specific: No

Details: Performance reports may be generated by the individual practice site, the medical group or individual practice association to which the practice belongs or an affiliated health plan.

The practice may use electronic systems to measure any of these items, but the element requires performance measurement whether or not electronic systems are available.

Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not only those covered by one payer.

Examples

Data Source: Reports from:

- manual review of a sample of patient records
- practice management system
- registry
- health plan-provided data
- larger medical group provided data
- electronic data base.

Element B: Patient Experience Data **3 points**

The practice collects data on patient experience with care in the following areas:	Yes	No
1. patient access to care	<input type="checkbox"/>	<input type="checkbox"/>
2. quality of physician communication	<input type="checkbox"/>	<input type="checkbox"/>
3. patient/family confidence in self care	<input type="checkbox"/>	<input type="checkbox"/>
4. patient/family satisfaction with care.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice collects data on 3-4 areas	No scoring option	Practice collects data on 1-2 areas	No scoring option	Practice does not collect data in any areas

Data Source Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Condition Specific: No

Details: Practices may use a phone survey or a paper or electronic survey.

Patient access to care may include the ability to make an appointment and see a physician, timeliness and quality of phone calls, office wait time.

Quality of physician communication may include response to questions, instructions and information about diagnosis, treatment, medication, follow up care. Practices may also incorporate questions about the degree to which patients and families feel that they are partners in the management of their health care.

Patient/family confidence in self-care may include patient knowledge of and ability to provide self-care involving activity, exercise, medications, reporting change in symptoms.

Patient/family satisfaction with care may include satisfaction with staff, physician and others, satisfaction with treatment and satisfaction with response to patient/family choices.

Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not only those covered by one payer.

Practices may qualify for 50% of points if they demonstrate that they have established a patient advocacy group or patient advisory board that meets periodically. Practices must provide documentation that such meetings are used to gather patient feedback.

Element C: Reporting to Physicians (must pass) **3 points**

The practice reports on performance on the measures in 8A and 8B:	Yes	No
1. across the practice	<input type="checkbox"/>	<input type="checkbox"/>
2. by individual physician.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice reports to physicians results both across the practice and by physician	No scoring option	Practice reports to physicians results either across the practice or by physician	No scoring option	No areas of performance reported to physicians

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Basic

Condition Specific: No

Details: The practice may utilize data that it produces itself or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plans. Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not just those covered by one payer. After the practice measures or receives performance data, it reports it to the practice as a whole and to individual physicians.

Practices have found meetings of physicians and staff to be an effective way to process and improve performance results.

Examples **Data Source:** Blinded reports showing summary practice performance or individual physician performance; blinded letters to physicians showing performance.

Element D: Setting Goals and Taking Action **3 points**

The practice uses performance data to:	Yes	No
1. set goals based on measurement results referenced in Elements 8A and 8B	<input type="checkbox"/>	<input type="checkbox"/>
2. take action where identified to improve performance of individual physicians or of the practice as a whole.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice does 2 items	No scoring option	Practice does 1 item	No scoring option	Practice does no items

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Basic

Condition Specific: No

Details: The practice should base goal setting on its own measurements as in element 8A. Examples of actions taken include providing such assistance as flow sheets or decision support to clinicians to prompt more systematic treatment. Goal setting and taking action include periodic remeasurement to assess progress and promote continuous quality improvement.

Practices may find it useful to involve patients and families in quality improvement activities.

Examples **Data Source:** Reports or completion of the PPC Quality Measurement and Improvement worksheet.

Element E: Reporting Standardized Measures **2 points**

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

[In the box to the right, enter the number of measures]

Scoring	100%	75%	50%	25%	0%
	Practice produces reports using 10 or more nationally approved performance measures	Practice produces reports using 5-9 nationally approved performance measures	Practice produces reports using 3-4 nationally approved performance measures	No scoring option	Practice produces reports using 0-2 nationally approved performance measures

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate
Condition Specific: No

Details: The intent is that the practice both measures and has the capability to report performance using measures that are currently endorsed by the National Quality Forum (NQF). As national measure sets are evolving, the practice should have the ability to report current measures as well as to program the reporting of new measures. The National Voluntary Consensus Standards for Ambulatory Care that are currently endorsed by the National Quality Forum for use at the physician or practice level may be accessed on the NQF Web site <http://www.qualityforum.org/projects/ongoing/ambulatory/index.asp> .

Reporting these measures requires that the practice have the ability to link a variety of data sources, including:

- standard ambulatory diagnoses and procedure codes (ICD, CPT)
- prescribed medications
- lab tests and results
- radiology data (ordered, results)
- blood pressure (value)
- standard inpatient diagnoses and procedure codes (DRG, CPT, ICD).

Examples **Data Source:** Reports showing performance measures calculated by practice.

Element F: Electronic Reporting—External Entities **1 point**

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

Scoring	100%	75%	50%	25%	0%
	Practice transmits 10 or more nationally approved performance measures to an external entity	Practice transmits at least 5-9 nationally approved performance measures to an external entity	Practice transmits 3-4 nationally approved performance measures to an external entity	Practice transmits 1-2 nationally approved measures to an external entity	Practice does not transmit any measures

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Advanced

Condition Specific: No

Details: This element assesses the practice's ability to report measures electronically to external entities.

If the system has the capability to transmit measures but has not done so, the practice may receive an override score of 25 percent.

Examples **Data Source:** Report to payer or other user from practice's electronic system.

PPC 9: Advanced Electronic Communication

4 points

The practice uses electronic communication to communicate with patients/families and other care providers.

Intent

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

Element A: Availability of Interactive Website

1 point

The practice provides patients/families with access to an interactive Website that allows them to :	Yes	No
1. request appointments by reviewing clinicians schedules	<input type="checkbox"/>	<input type="checkbox"/>
2. request referrals	<input type="checkbox"/>	<input type="checkbox"/>
3. request test results	<input type="checkbox"/>	<input type="checkbox"/>
4. request prescription refills	<input type="checkbox"/>	<input type="checkbox"/>
5. see elements of their medical record	<input type="checkbox"/>	<input type="checkbox"/>
6. import elements of their medical record into a personal health record.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice provides 5-6 items	Practice provides 4-5 items	Practice provides 2-3 items	Practice provides 1 item	Practice does not provide any items

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation IT Required: Intermediate

Condition Specific: No

Details: This element looks at ways practices can provide Web-based functionality that support patient access and patient-self-management.

Examples **Data Source:** Screen shots showing presence of Web-based functionality.

Element B: Electronic Patient Identification

2 pointS

The practice combines use of electronic information and clinical decision support to contact the following types of patients, once identified, by e-mail:	Yes	No
1. patients needing clinical review or action	<input type="checkbox"/>	<input type="checkbox"/>
2. patients on a particular medication	<input type="checkbox"/>	<input type="checkbox"/>
3. patients needing preventive care	<input type="checkbox"/>	<input type="checkbox"/>
4. patients needing specific tests	<input type="checkbox"/>	<input type="checkbox"/>
5. patients needing follow up visits	<input type="checkbox"/>	<input type="checkbox"/>
6. Patients who might benefit from disease or case management support.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses electronic information and communication for 5-6 items	Practice uses electronic information and communication for 3-4 items	Practice uses electronic information and communication for 1-2 items	No scoring option	Practice does not use electronic information for any items

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate
Condition Specific: No

Details: This element requires the practice to use electronic information to communicate with the patient by e-mail about specific needs.

Examples **Data Source:** Screen shots showing identification of patients for the above items and an example of e-mail communication with patients based on electronic identification.

Element C: Electronic Care Management Support **1 point**

For patients with the three clinically important conditions, the practice care management team uses electronic communication for the following:	Yes	No
1. to communicate with disease or case managers about patient needs	<input type="checkbox"/>	<input type="checkbox"/>
3. Web-based educational modules for patient self-management.	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
	Practice uses electronic communication for 2 items	Practices uses electronic information for 1 item	No scoring option	No scoring option	Practice does not use electronic communication for any items

Data source Reports

Scope of review ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Intermediate
Condition Specific: No

Details: This element identifies ways in which practices can use electronic communication to support the care management process.

Web-based education modules may be on the practice Website or through an arrangement with, and referral to, others.

Examples **Data Source:** Screen shots showing electronic communication about care management. Screen shots or links to education modules.