Tri-State Children's Health Improvement Consortium (T-CHIC):

MEDICAL HOME - OFFICE REPORT MEASUREMENT TOOL USER'S GUIDE

UPDATED OCTOBER 2012

OPIP
Oregon Pediatric
Improvement Partnership

October 9, 2012

T-CHIC MEDICAL HOME OFFICE REPORT MEASUREMENT REPORT TOOL

USERS GUIDE

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OVERVIEW OF THE MEDICAL HOME OFFICE REPORT MEASUREMENT TOOL

Background:

The **Tri-State Children's Health Improvement Consortium (T-CHIC)** Medical Home Office Report Measurement Tool is meant to collect standardized baseline and evaluation data across the twenty-one practices who are implementing medical home quality improvement efforts. This measurement tool will allow for comparisons to be made over time within and between practices. In addition, the Medical Home Measurement Tool measures key demographic characteristics of practices and their patients. **Appendix A** provides an overview of the baseline measure of medical home that being collected across the T-CHIC effort.

The purpose of the T-CHIC Medical Home Office Measurement Report Tool is to collect descriptive information about the participating office's characteristics and specific office systems/processes that have been demonstrated to be correlated with and/or predictive of an office's ability to provide medical home services **to children and youth**. Through the medical home improvement and enhancement work underway through the T-CHIC, is hypothesized that many of the office systems and processes assessed in this tool will be enhanced.

The specific components of this tool were identified because they are standardized, there is national comparative information available, and the specific measures in the tools address the various improvement efforts of focus across the T-CHIC. Specific sections of the tool are required by the CHIPRA Demonstration Grant National Evaluator (*Mathematica)*.

Content:

The Medical Home Office Report Measurement Tool consists of five Modules or specific sections:

Module 1. Demographic Form*
Module 2. Practice Characteristics*
Module 3. Medical Home Index (MHI): Revised Short Form (RSF)*
Module 4. National Committee for Quality Assurance Patient-Centered Medical Home 2011 (NCQA PCMH 2011)
Module 5. State-Specific Items (Oregon and Alaska Sites ONLY)

** Includes required data elements to be reported to the National Evaluator (Mathematica).*

The 5 modules are separate items and data for each module can be collected and saved independently.

Appendix B contains the **Glossary** for key terms that are used in the 5 modules.

If you have questions about the tool content or background on the development, you can contact Colleen Reuland at reulandc@ohsu.edu.

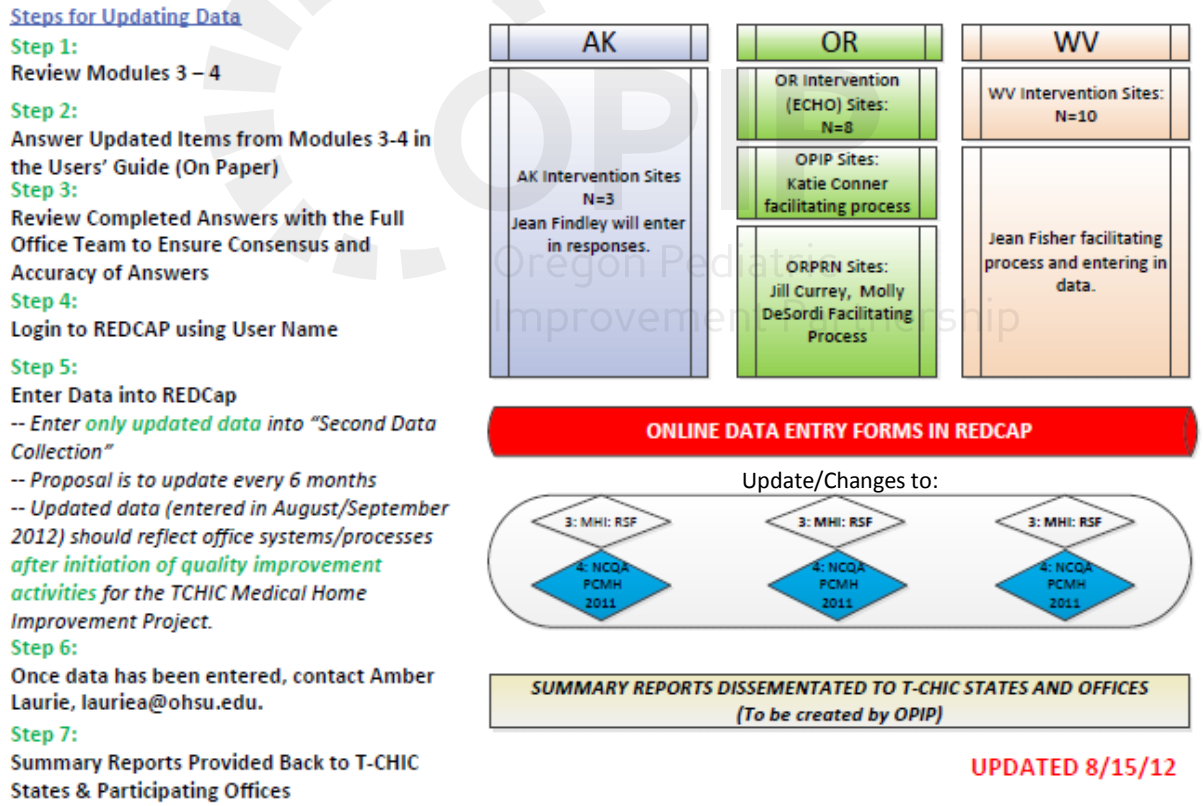
OVERVIEW OF DATA COLLECTION AND DATA ENTRY

The purpose of **this Users Guide** is to provide the offices or those working with the offices to collect the data with instructions and a list of items to used to facilitate the team-level conversations and meetings needed in order to provide specific answers to this tool.

- Office teams or persons working with the office teams should work with various staff members to answer all questions and gather the required data on paper.
- It is integral that the full office team review the proposed answers and confirm team consensus and agreement on the answers before the items are entered into the REDCap data entry system.
    - Past experience has shown that while a person needs to be charged with entering in the data, the full team responses should be reviewed in a group-setting to ensure office-level accuracy. Given that this tool is the primary evaluation tool to be used across T-CHIC, it is essential that the responses accurately reflect the office systems and characteristics.

The purpose **REDCap** tool is to provide a centralized place where the data can be entered for each of the participating offices (N=21) across T-CHIC. Figure 1 below provides an overview of the key steps in the data collection for this first update process and data entry process that is proposed across T-CHIC.

Figure 1: T-CHIC MEDICAL HOME OFFICE REPORT MEASUREMENT TOOL: Data Update Process

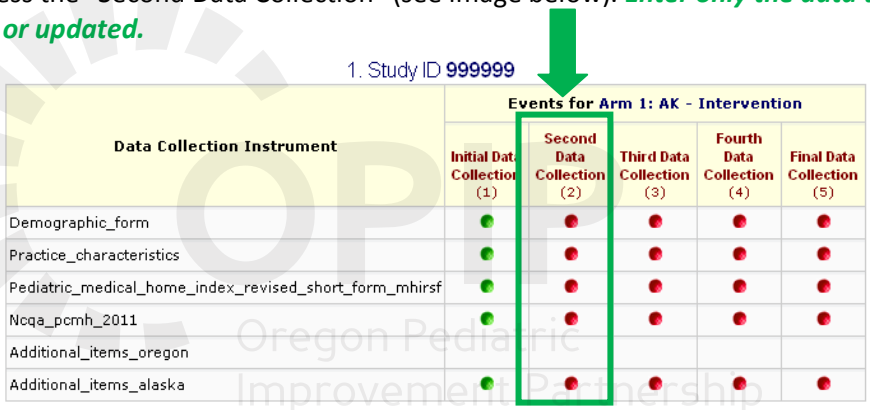


IMPORTANT NOTE ABOUT UPDATING THE DATA:

For the second round of data collection (to be entered in August–November 2012) it is important to answer the Medical Home Office Report Measurement Tool about your practice **after initiation of quality improvement activities for the T-CHIC Medical Home Improvement Activities**.

To complete the second round of data collection, please follow the instructions below.

1) You will receive a copy of your baseline answers to the full Medical Home Office Report Tool via email.
2) Review Module 3 (Medical Home Index: Revised Short Form) and Module 4 (National Committee for Quality Assurance 2011) ***with practices*** and update ***on paper*** any items that have changed for Module 3 (Medical Home Index: Revised Short Form) and Module 4 (National Committee for Quality Assurance 2011). Updated data should reflect office systems and processes ***after initiation of quality improvement activities*** for the T-CHIC Medical Home Improvement Project.
3) Review the completed answers with full office team. Please see page 6 for an "Important note about the team approach to answering the MHORT questions."
4) Login to REDCap using user name.
5) In Redcap, access the "Second Data Collection" (see image below). ***Enter only the data that has been changed or updated.***



6) Once data has been entered, select "Unverified" and contact Amber Laurie with OPIP at lauriea@ohsu.edu. For West Virginia and Alaska practices: enter updated items by November 30th. For Oregon practices: enter updated items by October 4th.

7) Summary reports will be provided back to T-CHIC states and participating offices.

It is currently proposed, for the non-control sites, that every six months the data will be updated to reflect the processes currently in place for the practice. The T-CHIC team will meet with each practice individually to coordinate updates and to provide training about how to update the tool will be provided by the Oregon Pediatric Improvement Partnership (OPIP) team.

IMPORTANT NOTE ABOUT THE TEAM APPROACH TO ANSWERING THE MHORT QUESTIONS

Studies have shown that office report tools can be inaccurate and unreliable if one person in the office completes the tool.

It is ***imperative*** that the responses are from a practice team to ensure consensus and shared understanding of what exists. Often the various responses lead to the most meaningful conversations and learnings about what processes do and do not exist.

1) Developers of office report tools recommend (at a minimum) champions at the **physician**, **nurse**, **office manager**, and **front-office level** review and provide input the responses.

2) This core team is also a helpful infrastructure for the QI work that needs to happen as it ensures champions at the various levels within the office work flow that are central to ensuring sustained change.

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SPECIFIC COMPONENTS OF THE MEDICAL HOME OFFICE REPORT TOOL:

On the following pages the specific items in the Medical Home Office Report Tool are listed. **Appendix B** contains the **Glossary** for key terms that are used in the items. Additionally, in the REDCap tool there are instructions that can be accessed. If you have specific questions about the terms/items in this tool please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

Note: In REDCap, use the Answer Grid Sheet Provided by OPIP to fill in the correct answer. This is noted in green below.

MODULE 1: DEMOGRAPHIC FORM

INSTRUCTIONS

Please complete the following items.

1. Study ID

   _____

   (**Use the Answer Grid Sheet Provided by OPIP to Fill in the Correct Answer -** A unique, assigned ID that allows for de-identification of practice Information)

2. Group ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A de-identified, assigned indicator to allow the grouping of analyses by state.)

3. CHIPRA Practice ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A unique, de-identified variable generated using the state's 2 letter postal abbreviation plus a 5-digit unique number (e.g., NC12345).

4. Indicate whether the practice is a CHIPRA Intervention practice intervention or comparison practice. (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER**)

   - ☐ Intervention practice
   - ☐ Intervention or comparison practice. Selected comparison practice with direct project
   - ☐ Interaction
   - ☐ Other comparison practice (no direct project interaction)
   - ☐ Unknown

5. Practice (Office-Level) National Plan & Provider Enumeration System (NPI):

   _____

   (A unique identifier that allows for merging of Medicaid administrative data with survey data.)
   (Unknown = U)

6. Date of Completion _____/_____/_____
   (mm / dd / yyyy)

7. Who completed the Demographic Form of the Medical Home Office Report Measurement Report Tool?

   - ☐ Lead physician/physician extender - alone
   - ☐ Other staff member – alone, please specify below
   - ☐ Lead physician/physician extender with other staff member
   - ☐ Other combination/group, please specify below
   - ☐ Performance Enhancement Research Specialist (PERCS)
   - ☐ T-CHIC Study Staff (Jean Fisher, Jean Findley, etc)
   - ☐ Other, please specify below
   - ☐ N/A, instrument not used
   - ☐ Unknown

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If your response is "Other staff member – alone" <u>OR</u> "other combination/group OR other, a text box labeled 7a. will appear for you to enter additional information.

7a. Other staff member – alone **<u>OR</u>** other combination/group **OR** other, please specify

_____

_____

8. Title/position/role of person taking lead in completing this Demographic Form.

Practice: Location and Contact

9. Clinic Name _____

10. Street Adddress_____

    _____

    City _____

    State _____

    Zip _____

11. Phone_____

12. Fax _____

13. Email _____

14. Who should we contact at your clinic if we have questions about your responses or if responses are missing/incomplete?

---

15. Title/Position/Role of Clinic Contact _____

16. Best phone number to reach clinic contact
    (if different from clinic contact phone number) _____

17. Contact email: _____

18. How many years has the practice been at this location (s)?_____

19. Do you consider the location of your practice to be primarily?

☐ Urban	>= 2,000 people per square mile, OR a total population >= 100,000 people AND a density >= 2,000 people per square mile, OR a total population >=l to 200,000 people.
☐ Suburban	<= 30 miles from urban areas, OR a density >= 500 people per square mile and < 2,000 people per square mile.
☐ Rural	population density <500 people per square mile
☐ Unknown	

20. How many practice sites do you have that share an electronic record system and standardized policies and procedures across all of the sites?

_____

*(**Note:** The purpose of this question is to identify the number of sites in a practice. If you do not have any sites that share these features, please enter 1 for your practice site. If you do not know, please enter 99.)*

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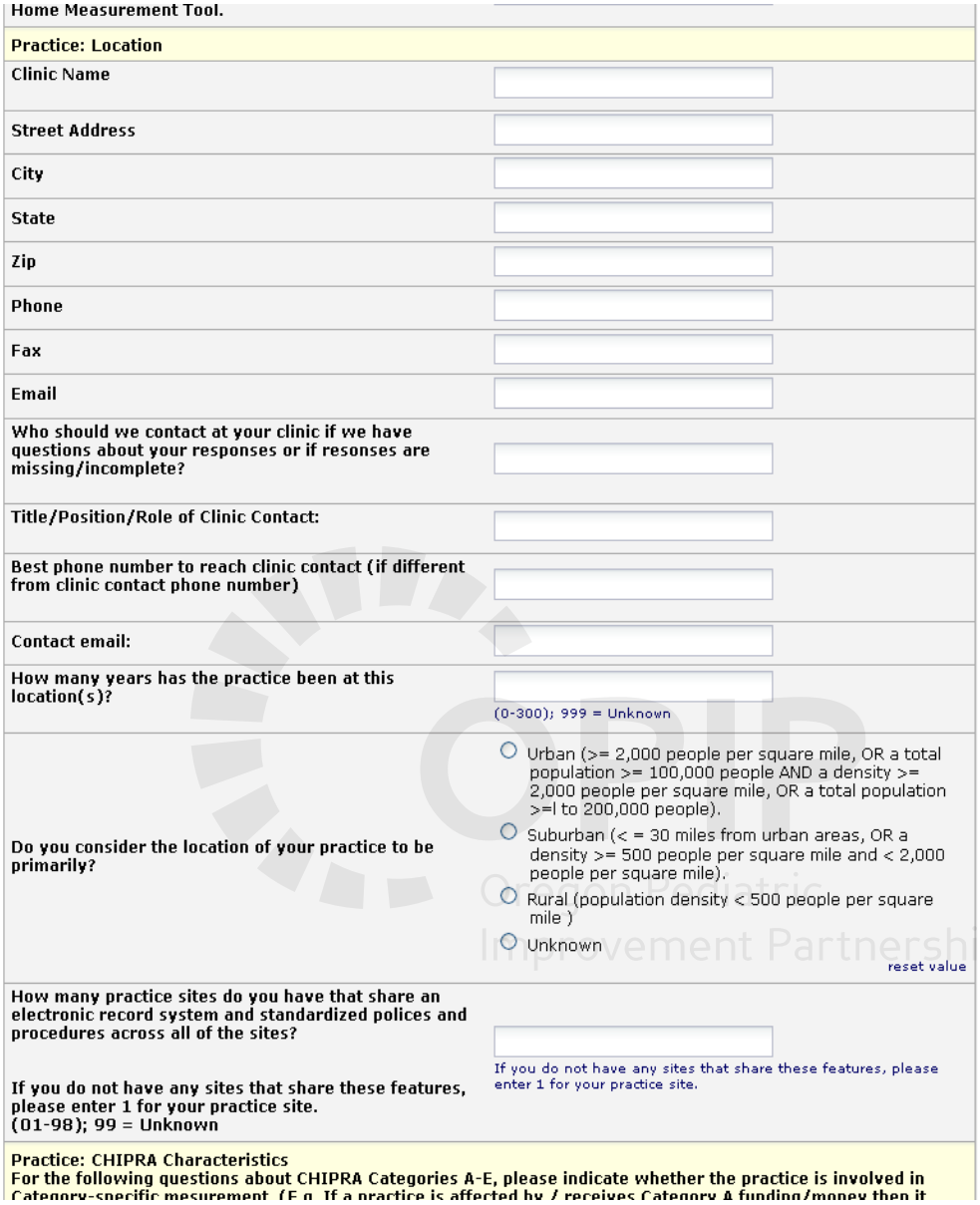
Below is an example of how the Demographic Form will appear in REDCap:



Home Measurement Tool.	
Practice: Location	
Clinic Name	
Street Address	
City	
State	
Zip	
Phone	
Fax	
Email	
Who should we contact at your clinic if we have questions about your responses or if resonses are missing/incomplete?	
Title/Position/Role of Clinic Contact:	
Best phone number to reach clinic contact (if different from clinic contact phone number)	
Contact email:	
How many years has the practice been at this location(s)?	(0-300); 999 = Unknown
Do you consider the location of your practice to be primarily?	○ Urban (>= 2,000 people per square mile, OR a total population >= 100,000 people AND a density >= 2,000 people per square mile, OR a total population >=l to 200,000 people). ○ Suburban (< = 30 miles from urban areas, OR a density >= 500 people per square mile and < 2,000 people per square mile). ○ Rural (population density < 500 people per square mile) ○ Unknown reset value
How many practice sites do you have that share an electronic record system and standardized polices and procedures across all of the sites? If you do not have any sites that share these features, please enter 1 for your practice site. (01-98); 99 = Unknown	If you do not have any sites that share these features, please enter 1 for your practice site.
Practice: CHIPRA Characteristics **For the following questions about CHIPRA Categories A-E, please indicate whether the practice is involved in Category-specific measurement. (E.g. If a practice is affected by / receives Category A funding/money then it**	

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Practice: CHIPRA Characteristics

For the following questions about CHIPRA Categories A-E, please indicate whether the practice is involved in Category-specific measurement. (E.g. If a practice is affected by / receives Category A funding/money then it participates in Category A activities).

21. Indicate whether the practice is involved in CHIPRA Practice not involved in CHIPRA Category A (quality measurement). **USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER**

    ☐ Practice not involved/ does not participate in CHIPRA Category A

    ☐ Practice involved in Category A activities or serves as a Category A comparison group

    ☐ Unknown

22. Indicate whether the practice is involved in CHIPRA Category B (HIT).
    USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER

    ☐ Practice not involved/ does not participate in CHIPRA Category B

    ☐ Practice involved in Category B activities or serves as a Category B comparison group

    ☐ Unknown

23. Indicate whether the practice is involved in CHIPRA Category C (PCMH/provider-based model)
    USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER

    ☐ Practice not involved/ does not participate in CHIPRA Category C

    ☐ Practice involved in Category C activities or serves as a Category C comparison group

    ☐ Unknown

24. Indicate whether the practice is involved in CHIPRA Category D (model PEHR)
    USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER

    ☐ Practice not involved/ does not participate in CHIPRA Category D

    ☐ Practice involved in Category D activities or serves as a Category D comparison group

    ☐ Unknown

25. Indicate whether the practice is involved in CHIPRA Category E (state's choice).
USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER

- ☐ Practice not involved/ does not participate in CHIPRA Category E
- ☐ Practice involved in Category E activities or serves as a Category E comparison group
- ☐ Unknown

26. What type of practice is this? (Check all that apply.)

- ☐ Solo practice
- ☐ Two physician practice
- ☐ Group practice with three or more physicians
- ☐ Group or staff model HMO
- ☐ Community health center
- ☐ Hospital run by state, county or city government
- ☐ Hospital run by a private for-profit or non-profit organization
- ☐ Medical school or university (private or government)
- ☐ Hospital run by Tribal
- ☐ Unknown
- ☐ Other, please specify below

If your response is "Other, please specify below", a text box labeled 26 a. will appear for you to enter additional information.

26a. Other, please specify _____

_____

*(**Note:** For clinic/outpatient departments of a hospital, please choose Medical school or university if it's affiliated with a medical school, otherwise select one of the hospital options.)*

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27. Who owns the practice? (Check all that apply)

- ☐ Physician or physician group
- ☐ Health Maintenance Organization (HMO)
- ☐ Community health center
- ☐ Medical/academic health center
- ☐ Other hospital
- ☐ Other health care corporation
- ☐ Other, please specify
- ☐ Tribal corporation
- ☐ Unknown
- ☐ Other, please specify below

If your response is "Other, please specify below", a text box labeled 27a. will appear for you to enter additional information.

27a. Other, please specify _____

_____

28. What is the specialty of MOST of the physicians in this practice?

- ☐ General pediatrics
- ☐ Family medicine
- ☐ General pediatrics with sub-specialty focus
- ☐ Pediatric sub-specialty
- ☐ Other, please specify below
- ☐ Unknown

If your response is "Other, please specify below", a text box labeled 28a. will appear for you to enter additional information.

28a. Other, please specify _____

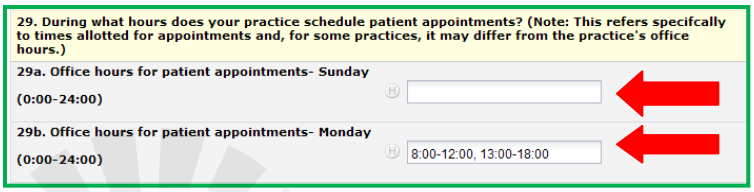
_____

29. During what hours does your practice schedule patient appointments?

Important Notes:

- *Please note this refers specifically to times allotted for appointments and, for some practices, it may differ from the practice's office hours.*
- *If the office is closed on the corresponding day, please leave this entry **blank**.*
- *For practices with multiple sites, please report the hours that any site in the practice schedules patient appointments.*
- ***If a practice has urgent care only hours, please enter the hours that staff are regularly present in the office.***
- *Please enter all times in military format.*

<u>For example</u>: An office that is closed on Sunday and is opened from 8:00 am – 6:00 pm with a 1 hour break for lunch and is closed from 12:00pm – 1:00pm on Monday should be entered as follows:



a. Office hours for patient appointments- **Sunday** _____
(0:00-24:00)
b. Office hours for patient appointments- **Monday** _____
(0:00-24:00)
c. Office hours for patient appointments- **Tuesday** _____
(0:00-24:00)
d. Office hours for patient appointments- **Wednesday** _____
(0:00-24:00)
e. Office hours for patient appointments- **Thursday** _____
(0:00-24:00)
f. Office hours for patient appointments- **Friday** _____
(0:00-24:00)
g. Office hours for patient appointments- **Saturday** _____
(0:00-24:00)

Practice Participation in Medical Home and Other Initiatives

30. Have you applied for NCQA PCMH medical home recognition?

☐ No → **Go to Question 33**

☐ Yes → **Go to Question 31**

☐ Unknown → **Go to Question 35**

31. When did you apply for NCQA PCMH medical home recognition?
*(**Note:** answer only if Question 30 is "Yes".)*

_____
(mm/yyyy)

32. When you applied for NCQA PCMH recognition, did you use the 2008 or 2011 application version?
*(**Note:** answer only if Question 30 is "Yes".)*

☐ 2008

☐ 2011

☐ Unknown

For all answers to Question 32 → **Go to Question 35**.

33. If you did not apply for NCQA PCMH recognition, are you planning on applying for NCQA PCMH 2011 recognition in the future?
*(**Note:** answer only if Question 30 is "No".)*

☐ No → **Go to Question 35**

☐ Yes → **Go to Question 34**

☐ Considering it → **Go to Question 35**

☐ Unknown → **Go to Question 35**

34. When are you planning to submit your application for NCQA PCMH 2011 recognition?
*(**Note:** answer only if Question 30 is "No" and Question 33 is "Yes".)*

_____

(mm/yyyy)

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Staff Characteristics

For each of the staff characteristics items, please enter 0 for the Number of staff (e.g. residents) and 0 for the Hours per week if your practice does not have this staff member.

Step 1: Please list the total number of staff (Note: This should be a whole number).

Step 2: Please list the total hours per week that all staff work.

Example: The practice employs 3 RNs.

The hours per week for these staff are: RN1 = 40 hours; RN2 = 30 hours; RN3 = 20 hours**.**
Total: 90 hours

35. Number of administrative staff? _____
(Unknown = 9999)

36. Hours per week for administrative staff _____
(Unknown = 9999)

37. Number of mental health clinicians _____
(Unknown = 9999)

38. Hours per week for mental health clinicians _____
(Unknown = 9999)

39. Number of dentists on staff _____
(Unknown = 9999)

40. Hours per week for dentists _____
(Unknown = 9999)

41. Number of Social Worker on staff _____
(Unknown = 9999)

42. Hours per week for social work staff _____
(Unknown = 9999)

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43. Number of business office staff _____
(Unknown = 9999)

44. Hours per week for business office staff _____
(Unknown = 9999)

45. Number of managed care administrative staff_____
(Unknown = 9999)

46. Hours per week for managed care administrative staff _____
(Unknown = 9999)

47. Number of information systems staff _____
(Unknown = 9999)

48. Hours per week for information systems staff_____
(Unknown = 9999)

49. Number of housekeeping staff _____
(Unknown = 9999)

50. Hours per week for housekeeping staff _____
(Unknown = 9999)

51. Number of Registered Nurses _____
(Unknown = 9999)

52. Hours per week for Registered Nurses _____
(Unknown = 9999)

53. Number of LPN _____
(Unknown = 9999)

54. Hours per week for LPN _____
(Unknown = 9999)

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55. Number of medical assistants / CNAs / Other clinical support staff _____ (Unknown = 9999)

56. Hours per week for medical assistants / CNAs / Other clinical support _____ (Unknown = 9999)

57. Number of medical receptionists _____ (Unknown = 9999)

58. Hours per week for medical receptionists _____ (Unknown = 9999)

59. Number of medical secretaries / transcribers _____ (Unknown = 9999)

60. Hours per week for medical secretaries / transcribers _____ (Unknown = 9999)

61. Number of medical records staff _____ (Unknown = 9999)

62. Hours per week for medical records staff _____ (Unknown = 9999)

63. Number of clinical laboratory staff _____ (Unknown = 9999)

64. Hours per week for clinical laboratory staff _____ (Unknown = 9999)

65. Number of radiology staff _____ (Unknown = 9999)

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66. Hours per week for radiology staff _____
(Unknown = 9999)

67. Number of residents? _____
(Unknown = 9999)

68. Hours per week for residents _____
(Unknown = 9999)

69. Number of other staff _____
(Unknown = 9999)

70. Hours per week for other staff _____
(Unknown = 9999)

Practice's Patient Mix

71. Count of the number of total patients (all ages) in patient roster _____
(Unknown = 999)

72. Count of the number of child and young adult (age 0-21) patients in patient roster. _____
(Unknown = 999)

73. What is your patient panel size? _____
(Unknown = 99999)

74. Percent of child and young adult (age 0-21) patients in the practice that have Medicaid _____%
(Unknown = 999)

75. Percent of Medicaid patients ages 0-21 years that are in fee-for-service (unrestricted) plans. _____%
(Unknown = 999)

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76. Percent of Medicaid patients ages 0-21 years that are in primary care case management (FFS Primary Care Case Management -PCCM or capitated PCCM) plans. (**If applicable**) _____% (Unknown = 999)

77. Percent of Medicaid patients ages 0-21 years that are in managed care. _____% (Unknown = 999)

78. Percent of child and young adult (age 0-21) patients in the practice that have CHIP _____% (Unknown = 999)
* We are aware that for Oregon practices this is unknown. Please code "999" .

79. Percent of child and young adult (age 0-21) patients in the practice that are uninsured. _____% (Unknown = 999)

80. Percent of child and young adult (age 0-21) patients in the practice that have Medicare. _____% (Unknown = 999)

81. Percent of child and young adult (age 0-21) patients in the practice that have Tricare. _____% (Unknown = 999)

82. Percent of child and young adult (age 0-21) patients in the practice that have private insurance. _____% (Unknown = 999)

83. Percent of child and young adult (age 0-21) patients in the practice that have private insurance AND Medicaid or Medicare. _____% (Unknown = 999)

84. Percent of child and young adult (age 0-21) patients in the practice that have other insurance. _____% (Unknown = 999)

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Provider Characteristics

Please list the names of clinicians currently in your practice include physician (M.D. or D.O.), physician assistant, and nurse practitioner, who see patients and may bill for professional service (including charting and follow-up). **(PRINT THIS SECTION (Pages 22-23) MULTIPLE TIMES FOR EACH OF THE PROVIDERS FOR WHOM YOU WILL BE ENTERRING IN DATA)**

Clinician One

85. First Name _____

86. Last Name _____

87. Provider -National Provider Identifier (NPI)_____
(A unique identifier that allows for merging of Medicaid administrative data with survey data.)
(Unknown = U)

88. Discipline
- ☐ MD / DO
- ☐ NP
- ☐ PA
- ☐ Other, please specify

Note: The term physician should be interpreted loosely and include the following providers: NP, PA and Other. Please complete specialty for these providers as follows:

- Pediatrics (e.g. PNP) = General Pediatrics
- Family Medicine (e.g. FNP) = Family Medicine
- Adult Medicine (e.g. ANP) = Other, please specify below
- Specialty other than listed = Other, please specify below

For example: Both a family nurse practitioner and a family practice physician's assistant would have the specialty of family medicine. A pediatric nurse practitioner or a general pediatrics PA would be coded as pediatric.

If your response is "Other, please specify below", a text box will appear for you to enter additional information.

Other discipline, please specify: _____

_____

89. What is the specialty of this physician?

- ☐ General pediatrics
- ☐ Family medicine
- ☐ General pediatrics with sub-specialty focus
- ☐ Pediatric sub-specialty
- ☐ Other, please specify below
- ☐ Unknown

If your response is "Other, please specify below", a text box will appear for you to enter additional information.

Other specialty of physician, please specify: _____

_____

90. FTE of this clinician in this practice _____
(Unknown = 999)

91. On average, how many hours does this clinician work per week? _____
(Unknown = 999)

92. One average, what percentage of this clinician's time is spent providing direct patient care?

_____%
(Unknown = 999)

93. What is the gender of this clinician?

- ☐ Male
- ☐ Female
- ☐ Unknown

94. How old is this clinician? _____ years
(Unknown = 999)

95. How many years has this clinician had his/her license? _____
(Unknown = 999)

Note: The Provider Characteristics are collected for all clinicians. REDCap currently has 50 clinician entries. Additional entries can be created for larger practices.

MODULE 2: PRACTICE CHARACTERISTICS

INSTRUCTIONS

Please complete the following items. **Appendix B** contains the **Glossary** for key terms that are used in the items. Additionally, in the REDCap tool there are instructions that can be accessed. If you have specific questions about the terms/items in this tool please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

Note: In REDCap, use the Answer Grid Sheet Provided by OPIP to fill in the correct answer. This is noted in green below.

1. Study ID _____
   (A unique, assigned ID that allows for de-identification of practice Information)
   USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER

2. Group ID _____
   (A de-identified, assigned indicator to allow the grouping of analyses by state.)
   USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER

3. Date of Completion _____/_____/_____
   (mm / dd / yyyy)

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4. Who completed Module 2 (Practice Characteristics) of this Medical Home Office Report Measurement Tool?

   - ☐ Lead physician/physician extender - alone
   - ☐ Other staff member – alone, please specify below
   - ☐ Lead physician/physician extender with other staff member
   - ☐ Other combination/group, please specify below
   - ☐ Performance Enhancement Research Specialist (PERCS)
   - ☐ T-CHIC Study Staff (Jean Fisher, Jean Findley, etc)
   - ☐ Other, please specify below
   - ☐ N/A, instrument not used
   - ☐ Unknown

If your response is "Other staff member – alone" <u>OR</u> "other combination/group OR other, a text box labeled 4a. will appear for you to enter additional information.

4a. Other staff member – alone **<u>OR</u>** other combination/group **OR** other, please specify
_____

_____

5. Title/position/role of person taking lead in completing Module 2 (Practice Characteristics) Medical Home Office Report Measurement Tool?

---

6. Do you provide telephone visits?
   - ☐ No → **Go to Question 8**
   - ☐ Yes → **Go to Question 7**
   - ☐ Unknown → **Go to Question 8**

7. What is the highest level of training for providers who have telephone visits with patients? (Please check all that apply)
   *(**Note:** answer only if Question 6 is "Yes".)*
   - ☐ MD/DO
   - ☐ ARNP
   - ☐ PA
   - ☐ RN
   - ☐ Other, please specify below
   - ☐ Not Applicable
   - ☐ Unknown

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If your response is "Other, please specify below", a text box will appear for you to enter additional information.

7a. Other, please specify: _____

_____

8. Do you provide email visits?

   ☐ No → **Go to Question 10**

   ☐ Yes → **Go to Question 9**

   ☐ Unknown → **Go to Question 10**

9. What is the highest level of training for providers who have email visits with patients? (Please check all that apply)
   *(**Note:** answer only if Question 8 is "Yes".)*

   ☐ MD/DO

   ☐ ARNP

   ☐ PA

   ☐ RN

   ☐ Other, please specify below

   ☐ Not Applicable

   ☐ Unknown

If your response is "Other, please specify below", a text box will appear for you to enter additional information.

9a. Other, please specify: _____

_____

10. Do you provide telemedicine visits?

    ☐ No → **Go to Question 12**

    ☐ Yes → **Go to Question 11**

    ☐ Unknown → **Go to Question 12**

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11. What is the highest level of training for providers who have telemedicine visits with patients? (Please check all that apply)
*(**Note:** answer only if Question 10 is "Yes".)*

- ☐ MD/DO
- ☐ ARNP
- ☐ PA
- ☐ RN
- ☐ Other, please specify below
- ☐ Not Applicable
- ☐ Unknown

If your response is "Other, please specify below", a text box will appear for you to enter additional information.

11a. Other, please specify: _____

_____

12. Do you provide visit reminders?

- ☐ No
- ☐ Yes
- ☐ Unknown

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13. Count of the average **number of visits** by patients ages **0-21 years** per week

_____
(999 = Unknown)

14. Percent of visits from patients ages 0-21 years that are covered by public insurance programs (Medicaid or CHIP)

_____ %
(999 = Unknown)

15. Is your practice currently accepting new patients?

    ☐ No

    ☐ Yes

Medical Record and Patient Information

16. Have you implemented and currently use and EMR?

    ☐ No → **Go to Question 17**

    ☐ Yes → **Go to Question 18**

    ☐ Unknown → **Go to Question 23**

17. Do you plan on implementing an EMR within the next three years?
    *(**Note:** answer only if Question 16 is "No".)*

    ☐ No

    ☐ Yes

    ☐ Unknown

    For all answers for Question 17→ Go to Question 23

18. How long (years) has your electronic health record been in use?
    *(**Note:** answer only if Question 16 is "Yes".)*

Please calculate the length of time that you have used your EHR, regardless of whether or not the EHR was certified. Note: This length of time does NOT refer to whether the EHR has been certified or the length of time that you have been using a certified EHR.

_____
(999= Unknown)

19. What EMR vendor do you use?
    *(**Note:** answer only if Question 16 is "Yes" or if Question 16 is "No" AND Question 17 is "Yes".)*

_____
(88 = NA)

20. Do you have internal capacity to be able to modify your EMR to do the following (Check all that apply):
*(**Note:** answer only if Question 16 is "Yes".)*

    ☐ Modify forms?

    ☐ Develop prompting or reminder systems?

    ☐ Run queries or sequel reports summarizing information across multiple patients?

21. Do you have one or more persons on staff in your practice whose primary role and responsibility is to enhance your EMR to meet your practice's needs?
*(**Note:** answer only if Question 16 is "Yes".)*

    ☐ No

    ☐ Yes

    ☐ Unknown

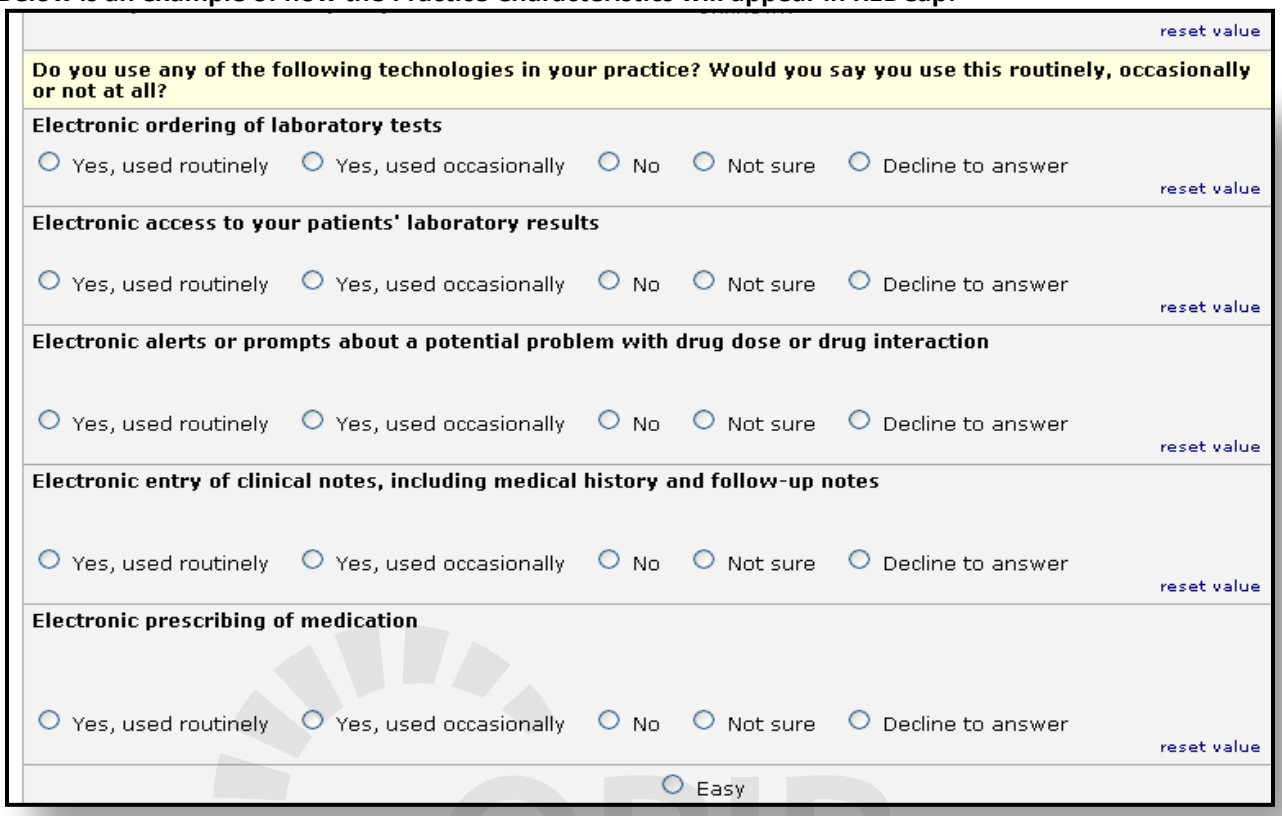
22. Has your practice met the meaningfulness use criterion for your EMR?
*(**Note:** answer only if Question 16 is "Yes".)*

    ☐ No
    ☐ Yes
    ☐ We are currently working towards achieving meaningful use
    ☐ Unknown

23. Do you use any of the following technologies in your practice? Would you say you use this routinely, occasionally or not at all? (Check the appropriate box for each item a-e)

	Yes, used routinely	Yes, used occasionally	No	Not Sure	Declined to answer
a. Electronic ordering of lab tests					
b. Electronic access to your patients' laboratory results					
c. Electronic alerts or prompts about a potential problem with drug dose or drug interaction					
d. Electronic entry of clinical notes, including medical history and follow-up notes					
e. Electronic prescribing of medication					

Below is an example of how the Practice Characteristics will appear in REDCap:



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24. With the patient medical records system you currently have, how easy would it be for you (or staff in your practice) to generate a list of patients by diagnosis (e.g., diabetes)?

- ☐ Easy
- ☐ Somewhat difficult
- ☐ Difficult
- ☐ Cannot generate → **Go to Question 26**
- ☐ Not sure
- ☐ Decline to answer → **Go to Question 26**

25. Is this process computerized?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Decline to answer

26. With the patient medical records system you currently have, how easy would it be for you (or staff in your practice) to generate a list of patients by lab result (e.g., HbA1C or Hgb, > 10.0)?

- ☐ Easy
- ☐ Somewhat difficult
- ☐ Difficult
- ☐ Cannot generate → **Go to Question 28**
- ☐ Not sure
- ☐ Decline to answer → **Go to Question 28**

27. Is this process computerized?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Decline to answer

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28. With the patient medical records system you currently have, how easy would it be for you (or staff in your practice) to generate a list of patients who are due or overdue for tests or preventive care (e.g., flu vaccine due)?

- ☐ Easy
- ☐ Somewhat difficult
- ☐ Difficult
- ☐ Cannot generate → **Go to Question 30**
- ☐ Not sure
- ☐ Decline to answer → **Go to Question 30**

29. Is this process computerized?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Decline to answer

30. With the patient medical records system you currently have, how easy would it be for you (or staff in your practice) to generate a list of all medications taken by an individual patient (including those that may prescribed by other doctors)?

- ☐ Easy
- ☐ Somewhat difficult
- ☐ Difficult
- ☐ Cannot generate → **Go to Question 32**
- ☐ Not sure
- ☐ Decline to answer → **Go to Question 32**

31. Is this process computerized?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Decline to answer

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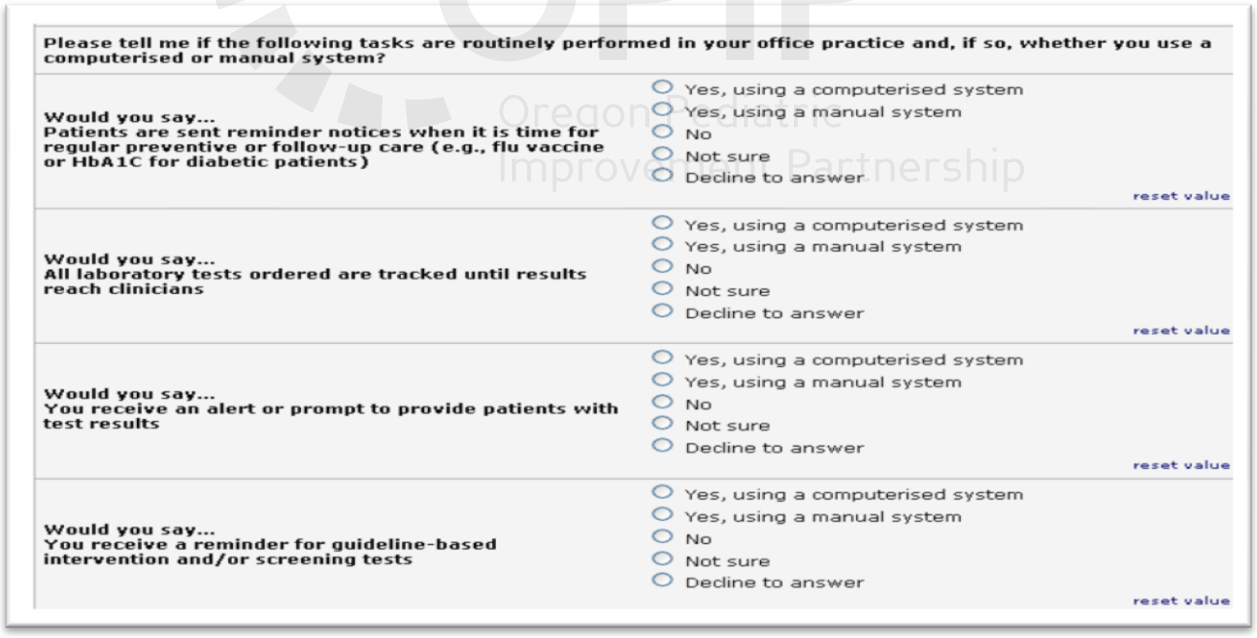
32. Please tell me if the following tasks are routinely performed in your office practice and, if so, whether you use a computerized or manual system? (Check the appropriate box for each item a-d)

	Yes, using a computerized system	Yes, using a manual system	No	Not sure	Declined to answer
a. Patients are sent reminder notices when it is time for regular preventive or follow-up care (e.g., flu vaccine or HbA1C for diabetic patients)					
b. All laboratory tests ordered are tracked until results reach clinicians					
c. You receive an alert or prompt to provide patients with test results					
d. You receive a reminder for guideline-based intervention and/or screening tests					

Below is an example of how the Practice Characteristics will appear in REDCap:



Practice Participation in Medical Home and Other Initiatives

33. During the last twelve months, did your practice use any of the following quality improvement (QI) techniques for projects or activities? (Please check all that apply.)

Evidence-based

- ☐ Implementing Clinical practice guidelines
- ☐ Checklists in records
- ☐ Patient Safety Protocols

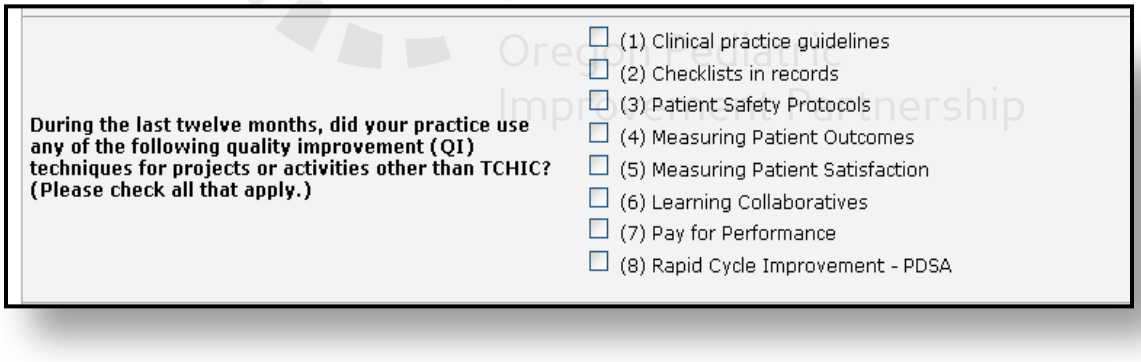
Patient Feedback

- ☐ Measuring Patient Outcomes
- ☐ Measuring Patient Satisfaction

Group-based

- ☐ Participate in a Learning Collaborative
- ☐ Participate in Pay for Performance effort
- ☐ Rapid Cycle Improvement – PDSA improvement activity

Below is an example of how the Practice Characteristics will appear in REDCap:



34. Is this practice currently involved in any medical home or quality improvement initiatives other than the CHIPRA Quality Demonstration Grant and T-CHIC Effort?

    ☐ No → **Go to Question 36**

    ☐ Yes → **Go to Question 35**

    ☐ Unknown → **Go to Question 36**

35. Please list previous or current other quality improvement projects.
    *(**Note:** answer only if Question 34 is "Yes".)*

1. _____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____

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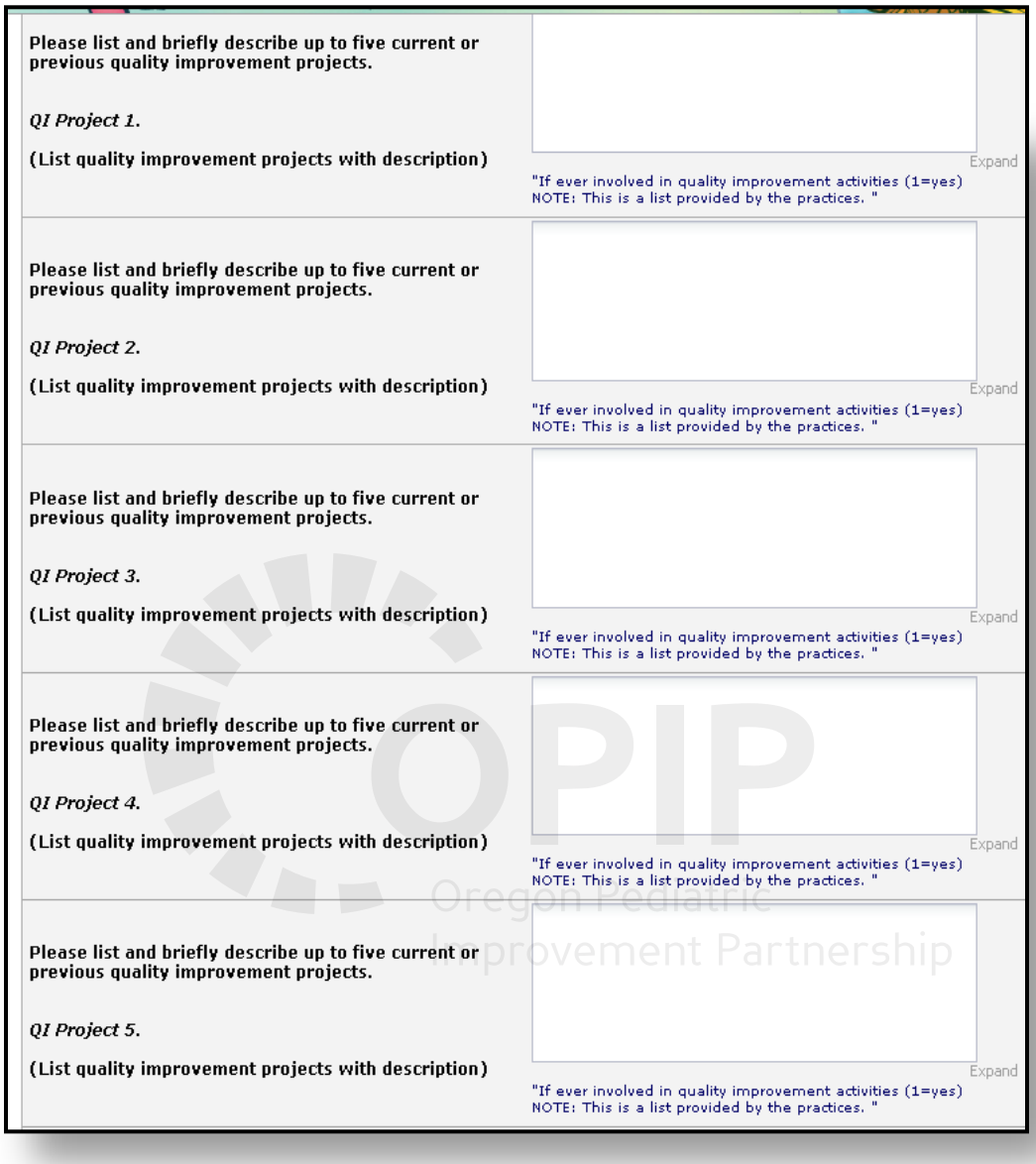
Below is an example of how the Practice Characteristics will appear in REDCap:



Please list and briefly describe up to five current or previous quality improvement projects. *QI Project 1.* **(List quality improvement projects with description)**	Expand "If ever involved in quality improvement activities (1=yes) NOTE: This is a list provided by the practices. "
Please list and briefly describe up to five current or previous quality improvement projects. *QI Project 2.* **(List quality improvement projects with description)**	Expand "If ever involved in quality improvement activities (1=yes) NOTE: This is a list provided by the practices. "
Please list and briefly describe up to five current or previous quality improvement projects. *QI Project 3.* **(List quality improvement projects with description)**	Expand "If ever involved in quality improvement activities (1=yes) NOTE: This is a list provided by the practices. "
Please list and briefly describe up to five current or previous quality improvement projects. *QI Project 4.* **(List quality improvement projects with description)**	Expand "If ever involved in quality improvement activities (1=yes) NOTE: This is a list provided by the practices. "
Please list and briefly describe up to five current or previous quality improvement projects. *QI Project 5.* **(List quality improvement projects with description)**	Expand "If ever involved in quality improvement activities (1=yes) NOTE: This is a list provided by the practices. "

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36. Do you conduct a patient experience of care survey at this practice?

- ☐ No
- ☐ Yes
- ☐ Unknown

37. What patient experience of care survey do you use?
*(**Note:** answer only if Question 36 is "Yes".)*

_____

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MODULE 3: Pediatric Medical Home Index- Revised Short Form (MHI-RSF)

INSTRUCTIONS

The Pediatric Medical Home Index (MHI) is a validated self-assessment and classification tool designed to translate the broad indicators defining the medical home (accessible, family-centered, comprehensive, coordinated, etc.) into observable, tangible behaviors and processes of care within any office setting. It is a way of measuring and quantifying the "medical homeness" of a primary care practice. The MHI is based on the premise that "medical home" is an evolutionary process rather than a fully realized status for most practices. The MHI measures a practice's progress in this developmental process. More information about the MHI can be found here: http://www.medicalhomeimprovement.org/knowledge/practices.html#measurement

The MHI defines, describes, and quantifies activities related to the organization and delivery of primary care for all children and youth. A population of vulnerable children and youth, including those with special health care needs, benefit greatly from having a high quality medical home. Medical Home represents the standard of excellence for pediatric primary care; this means the primary care practice is ready and willing to provide well, acute and chronic care for all children and youth, including those affected by special health care needs or who hold other risks for compromised health and wellness.

The MHI-Revised Short Form (MHI-RSF) is a subset of 14 items from the MHI that is required by the National Evaluator across all of the T-CHIC sites. **You will notice that the number in the left hand column are not in numeric order (1.1, 1.2, 1.5, etc.) This is because this numbering maps to the fuller MHI.**

You will be asked to rank the level (1-4) of your practice in six domains: organizational capacity, chronic condition management, care coordination, community outreach, data management and quality improvement/change. Most practices may not function at many of the higher levels (Levels 3 and 4). However these levels represent the kinds of services and support which families report that they need from their medical home.

Please access the glossary link located in the Medical Home Report Tool or Appendix A of the Medical Home Report Tool User's Guide.

If you have specific questions about the terms/items in this tool please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

Note: In REDCap, use the Answer Grid Sheet Provided by OPIP to fill in the correct answer. This is noted in green below.

1. Study ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A unique, assigned ID that allows for de-identification of practice Information)

2. Group ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER) -** A de-identified, assigned indicator to allow the grouping of analyses by state.)

3. Date of Completion

   _____/_____/_____

   (mm / dd / yyyy)

4. Who completed Module 3 (MHI-RSF) of this Medical Home Office Report Measurement Tool?

   - ☐ Lead physician/physician extender - alone
   - ☐ Other staff member – alone, please specify below
   - ☐ Lead physician/physician extender with other staff member
   - ☐ Other combination/group, please specify below
   - ☐ Performance Enhancement Research Specialist (PERCS)
   - ☐ T-CHIC Study Staff (Jean Fisher, Jean Findley, etc)
   - ☐ Other, please specify below
   - ☐ N/A, instrument not used
   - ☐ Unknown

   If your response is "Other staff member – alone" <u>OR</u> "other combination/group OR other, a text box labeled "4a." will appear for you to enter additional information.

   4a. Other staff member – alone **<u>OR</u>** other combination/group **OR** other, please specify

   _____

   _____

5. Title/position/role of person taking lead in completing Module 3 (MHI-RSF) of this Medical Home Office Report Measurement Tool.

Background Questions

6. Is there a care coordinator working at your practice who supports children, youth, and families?

   ☐ No → **Go to Question 9**

   ☐ Yes → **Go to Question 7**

   ☐ N/A, instrument not used → **Go to Question 9**

   ☐ Unknown → **Go to Question 9**

7. Where is the care coordinator located?
   *(**Note**: answer only if Question 6 is "Yes".)*

   ☐ At the practice

   ☐ At other site, please specify below.

   ☐ Unknown

If your response is "Other, please specify below", a text box will appear for you to enter additional information.

7a. At other site, please specify:

_____

_____

8. What is the care coordinator's highest level of training?
   *(**Note**: answer only if Question 6 is "Yes".)*

   ☐ RN

   ☐ MA/CNA

   ☐ LPN

   ☐ SW

   ☐ Other, please specify _____

   ☐ Unknown

If your response is "Other, please specify below", a text box will appear for you to enter additional information.

8a.Other, please specify:

_____

_____

9. How familiar/knowledgeable are you about the concept of a medical home as defined by the **American Academy of Pediatrics (AAP)** (See Appendix B http://aappolicy.aappublications.org/cgi/reprint/pediatrics;110/1/184.pdf)? ***Please do not select "N/A Instrument not used."***

- ☐ No knowledge of the concepts
- ☐ Some knowledge/not applied
- ☐ Knowledgeable/concept sometimes applied in practice
- ☐ Knowledgeable/concepts regularly applied in practice
- ☐ Knowledgeable / concept not applied in practice
- ☐ N/A, instrument not used
- ☐ Unknown

WARNING!! Please save the data that you have entered before you click on the AAP link. Otherwise, your data will be lost when you return to REDCap.

10. How familiar/knowledgeable are you about the elements of family-centered care as defined by the **US Maternal and Child Health Bureau (**see Appendix B)? ***Please do not select "N/A Instrument not used."***

- ☐ No knowledge of the concepts
- ☐ Some knowledge/not applied
- ☐ Knowledgeable/concept sometimes applied in practice
- ☐ Knowledgeable/concepts regularly applied in practice
- ☐ Knowledgeable / concept not applied in practice
- ☐ N/A, instrument not used
- ☐ Unknown

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The Medical Home Index: Revised Short Form: Pediatric

Measuring the Organization and Delivery of Pediatric Primary Care for *All* Children, Youth, and Families

INSTRUCTIONS:
This instrument is organized under six domains: 1) Organizational Capacity, 2) Chronic Condition Management, 3) Care Coordination, 4) Community Outreach, 5) Data Management, 6) Quality Improvement

Each domain has anywhere from 1-4 themes, these themes are represented with progressively comprehensive care processes and are expressed as a continuum from Level 1 through Level 4. For each theme please do the following:

First: Read each theme across its progressive continuum from Levels 1 to Level 4.

Second: Select the LEVEL (1, 2, 3 or 4) which best describes how your *practice* currently provides care for patients with chronic health conditions.

Third: When you have selected your Level, please indicate whether *practice* performance within that level is: **"*PARTIAL*"** (some activity within level) or **"*COMPLETE*"** (all activity within that level).

Fourth: For each theme, please provide any additional information in the Comments box.

For the example below, **"Domain 1: Organizational Capacity, Theme 1. 1 "The Mission..."** the score for the *practice* is: **"Level 3", "PARTIAL".**

Requires both MD and key non-MD staff person's perspective - you will see this declaration before select themes; CMHI (the developers of the MHI) have determined that these questions require the input of both MD and non MD staff to best capture practice activity.

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Definitions of Core Concepts (Words in *italics* throughout the document are defined below.) **AS Defined by MHI-RSF. READ THROUGH BEFORE COMPLETING.**

Children with Special Health Care Needs (CSHCN):

Children with special health care needs are defined by the US Maternal and Child Health Bureau as those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997).

Medical Home:

A medical home is a community-based primary care setting which provides and coordinates high *quality*, planned, patient/family-centered: health promotion (acute, preventive) and *chronic condition management* (© CMHI, 2006).

Family-Centered Care (US Maternal and Child Health Bureau, 2004):

Family-centered care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-centered care is the standard of practice which results in high quality services.

Glossary of Terms

Practice-Based Care Coordination

Care and services performed in partnership with the family and providers by health professionals to:

1) Establish family-centered community-based Medical Homes for ***CSHCN*** and their families.

   -Make assessments and monitor child and family needs

   -Participate in parent/professional practice improvement activities

2) Facilitate timely access to the ***Primary Care Provider*** (***PCP***), services and resources

   -Offer supportive services including counseling, education and listening

   -Facilitate communication among PCP, family and others

3) Build bridges among families and health, education and social services; promotes continuity of care

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-Develop, monitor, update and follow-up with care planning and care plans

-Organize wrap around teams with families; support meeting recommendations and follow-up

4) Supply/provide access to referrals, information and education for families across systems.

-Coordinate inter-organizationally

-Advocate with and for the family (e.g. to school, day care, or health care settings)

5) Maximize effective, efficient, and innovative use of existing resources

-Find, coordinate and promote effective and efficient use of current resources

-Monitor outcomes for child, family and practice

Chronic Condition Management (CCM):

CCM acknowledges that children and their families may require more than the usual well child, preventive care, and acute illness interventions. CCM involves explicit changes in the roles of providers and office staff aimed at improving:

1) Access to needed services

2) Communication with specialists, schools, and other resources, and

3) Outcomes for patients, families, *practices*, employers and payers.

Quality:

Quality is best determined or judged by those who need or who use the services being offered. *Quality* in the medical home is best achieved when one learns what children with special health care needs and their families require for care and what they need for support. Health care teams in partnership with families then work together in ways which enhance the capacity of the family and the practice to meet these needs. Responsive care is designed in ways which incorporate family needs and suggestions. Those making practice improvements must hold a commitment to doing what needs to be done and agree to accomplish these goals in essential partnerships with families.

Office Policies:

Definite courses of action adopted for expediency; "the way we do things"; these are clearly articulated to and understood by all who work in the office environment.

Practice:

The place, providers, and staff where the PCP offers pediatric care

Primary Care Provider - (PCP):

Physician or pediatric nurse practitioner who is considered the main provider of health care for the child

United States Maternal and Child Health Bureau - (USMCHB):

A division of Health Resources Services Administration

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For each theme, please select <u>only one level</u> and check partial or complete within that level. (For example, if the highest level that your practice has reached is level 2 and it is complete, <u>only</u> check the complete box within level 2. In this example, it is assumed that level 1 has been completed and you do not need to check this.)

Domain 1: Organizational Capacity:				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#1.1 **The Mission** **of the *Practice***	*Primary care providers (PCPs)* at the *practice* have individual ways of delivering care to children with special health care needs CSHCN; their own education, experience and interests drive care quality. ❒ PARTIAL ❒ COMPLETE	*Approaches to the care of CSHCN* at the *practice* are child rather than *family-centered*; office needs drive the implementation of care (e.g. the process of carrying out care). ❒ PARTIAL ❒ COMPLETE	The practice uses a *family-centered* approach to care **(see pages 44-46)**, they assess *CSHCN* and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policy (e.g. the way things are done). ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, a parent/ ***practice*** "advisory group" promotes ***family-centered*** strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for ***CSHCN*** and their families. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 1: Organizational Capacity: For Children with Special Health Care Needs (CSHCN) and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#1.2 **Communication/ Access**	Communication between the family and the PCP occurs as a result of family inquiry; PCP contacts with the family are for test result delivery or planned medical follow-up. ❒ PARTIAL ❒COMPLETE	In addition to Level 1, standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours). ❒ PARTIAL ❒ COMPLETE	Practice and family communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt weekend or other special appointments. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g. fax, e-mail or web messages, home, school or residential care visits). ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 1: Organizational Capacity: For Children with Special Health Care Needs (CSHCN) and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#1.5 Family Feedback ***Requires both MD and key non-MD Staff person's perspective.***	Family feedback to the *practice* occurs through external mechanisms such as satisfaction surveys issued by a health plan; this information is not always shared with practice staff. ❒ PARTIAL ❒COMPLETE	Feedback from families of *CSHCN* is elicited sporadically by individual practice providers or by a suggestion box; this feedback is shared informally with other providers and staff. ❒ PARTIAL ❒ COMPLETE	Feedback from families of *CSHCN* regarding their perception of care is gathered through systematic methods (e.g. surveys, focus groups, or interviews); there is a process for staff to review this feedback and to begin problem solving. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, an advisory process is in place with families of *CSHCN* which helps to identify needs and implement creative solutions; there are tangible supports to enable families to participate in these activities (e.g. childcare or parent stipends). ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 1: Organizational Capacity: For Children with Special Health Care Needs (CSHCN) and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#1.6 Cultural Competence	The *primary care provider* (*PCP*) attempts to overcome obstacles of language, literacy, or personal preferences on a case by case basis when confronted with barriers to care. ❒ PARTIAL ❒COMPLETE	In addition to Level 1, resources and information are available for families of the most common diverse cultural backgrounds; others are assisted individually through efforts to obtain translators or to access information from outside sources. ❒ PARTIAL ❒ COMPLETE	In addition to Level 2, materials are available and appropriate for non- English speaking families, those with limited literacy; these materials are appropriate to the developmental level of the child/young adult. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, family assessments include pertinent cultural information, particularly about health beliefs; this information is incorporated into care plans; the *practice* uses these encounters to assess patient & community cultural needs. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 2: *Chronic Condition Management (CCM)*: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#2.1 Identification of Children in the Practice with Special Health Care Needs	Children with special health care needs (*CSHCN)* can be counted informally (e.g. by memory or from recent acute encounter); comprehensive identification can be done through individual chart review only. ❒ PARTIAL ❒COMPLETE	Lists of children with special health care needs are extracted electronically by diagnostic code. ❒ PARTIAL ❒ COMPLETE	A CSHCN list is generated by applying a definition **(see pages 44-46)**, the list is used to enhance care +/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups) ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, diagnostic codes for CSHCN are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible practice database. ❒ PARTIAL ❒ COMPLETE
Comments				

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What is your process for identifying children with special health care needs?

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Domain 2: *Chronic Condition Management (CCM)*: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#2.2 **Care Continuity**	Visits occur with the child's own primary care provider (PCP) as a result of acute problems or well child schedules; the family determines follow up. ❒ PARTIAL ❒COMPLETE	Non-acute visits occur with families and their PCP to address chronic condition care; the PCP determines appropriate visit intervals; follow-up includes communication of tasks to staff and of lab and medical test results to the family. ❒ PARTIAL ❒ COMPLETE	The team (including PCP, family, and staff) develops a plan of care for *CSHCN* which details visit schedules and communication strategies; home, school and community concerns are addressed in this plan. Practice back up/cross coverage providers are informed by these plans. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, the practice/teams use condition protocols; they include goals, services, interventions and referral contacts. A designated care coordinator uses these tools and other standardized office processes which support children and families. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 2: *Chronic Condition Management (CCM)*: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#2.4 **Cooperative Management Between Primary Care Provider *(PCP)* and Specialists**	Specialty referrals occur in response to specific diagnostic and therapeutic needs; families are the main initiators of communication between specialists and their primary care provider (PCP). ❒ PARTIAL ❒COMPLETE	In addition to Level 1, specialty referrals use phone, written and/or electronic communications; the PCP waits for or relies upon the specialists to communicate back their recommendations. ❒ PARTIAL ❒ COMPLETE	The PCP and family set goals for referrals and communicate these to specialists; together they clarify co-management roles among family, PCP and specialists and determine how specialty feedback to the family and PCP is expressed, used, and shared. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, the family has the option of using the *practice* in a strong coordinating role; parents as partners with the *practice* manage their child's care using specialists for consultations and information (unless they decide it is prudent for the specialist to manage the majority of their child's care). ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 2: *Chronic Condition Management (CCM)*: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#2.5.1 **Supporting** **the** **Transition to** **Adulthood** **** transition measure*** ***revised August,*** ***2006.***	Pediatric and adolescent primary care providers (PCPs) adhere to defined health maintenance schedules for youth with special health care needs in their practice. ❒ PARTIAL ❒COMPLETE	Pediatric and adolescent PCPs offer age appropriate anticipatory guidance for specific youth & families related to their chronic condition, self-care, nutrition, fitness, sexuality, and other health behavior information. ❒ PARTIAL ❒ COMPLETE	Pediatric and adolescent PCPs support youth & family to manage their health using a transition time line & developmental approach; they assess needs & offer culturally effective guidance related to: • health & wellness • education & vocational planning • guardianship and legal & financial issues • community supports & recreation When youth transition from pediatrician to adult provider: **Pediatricians** help to identify an adult PCP and sub-specialists and offer ongoing consultation to youth, family and providers during the transition process. **Adult Providers** offer an initial "welcome" visit and a review of transition goals. ❒ PARTIAL ❒ COMPLETE	In addition to level 3, progressively from age 12, youth, family and PCP develop a written transition plan within the care plan; it is made available to families and all involved providers. Youth and families receive coordination support to link their health and transition plans with other relevant adolescent and adult providers/services/ agencies (e.g. sub-specialists, educational, financial, insurance, housing, recreation employment and legal assistance). ❒ PARTIAL ❒ COMPLETE
2.5.1 Comments				

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Domain 3: Care Coordination: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#3.1 Care Coordination /Role Definition	The family coordinates care without specific support; they integrate office recommendations into their child's care. ❒ PARTIAL ❒COMPLETE	The *primary care provider* (*PCP*) or a staff member engages in care support activities as needed; involvement with the family is variable. ❒ PARTIAL ❒ COMPLETE	Care coordination activities are based upon ongoing assessments of child and family needs; the practice partners with the family (and older child) to accomplish care coordination goals. ❒ PARTIAL ❒ COMPLETE	Practice staff offer a set of care coordination activities **(see pages 44-46)**, their level of involvement fluctuates according to family needs/wishes. A designated care coordinator ensures the availability of these activities including written care plans with ongoing monitoring. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 3: Care Coordination: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#3.2 **Family** **Involvement**	The PCP makes medical recommendations and defines care coordination needs; the family carries these out. ❒ PARTIAL ❒COMPLETE	Families (and their older *CSHCN* are regularly asked what care supports they need; treatment decisions are made jointly with the *PCP*. ❒ PARTIAL ❒ COMPLETE	In addition to Level 2, families (and older CSHCN) are given the option of centralizing care coordination activities at and in partnership with the *practice*. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, children & families contribute to a description of care coordination activities; a care coordinator specifically develops and implements this practice capacity which is evaluated by families and designated supervisors. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 3: Care Coordination: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#3.4 Assessment of Needs/ Plans of Care	Presentation of CSHCN with acute problems determines how needs are addressed. ❒ PARTIAL ❒COMPLETE	PCPs identify specific needs of CSHCN; follow-up tasks are arranged for, or are assigned to families &/or available staff. ❒ PARTIAL ❒ COMPLETE	The child with special needs, family, and PCP review current child health status and anticipated problems or needs; they create/ revise action plans and allocate responsibilities at least 2 times per year or at individualized intervals. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, the *PCP*/staff and families create a written plan of care that is monitored at every visit; the office care coordinator is available to the child and family to implement, update and evaluate the care plan. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 4: Community Outreach: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#4.1 Community Assessment of Needs for CSHCN	*Primary care provider (PCP)* awareness of the population of children with special health care needs *CSHCN* in their community is directly related to the number of children for whom the provider cares. ❒ PARTIAL ❒COMPLETE	The practice learns about issues and needs related to *CSHCN*s from key community informants; providers blend this input with their own personal observations to make an informal and personal assessment of the needs of *CSHCN* in their community. ❒ PARTIAL ❒ COMPLETE	In addition to Level 2, providers raise their own questions regarding the population of *CSHCN* in their practice community; they seek pertinent data and information from families and local/state sources and use data to inform practice care activities. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, at least one clinical practice provider participates in a community-based public health need assessment about *CSHCN*, integrates results into practice policies, and shares conclusions about population needs with community & state agencies. ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 5: Data Management: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#5.1 Electronic Data **Support**	*Primary care providers (PCPs)* retrieve information/data by individual chart review; electronic data are available and retrievable from payer sources only. ❒ PARTIAL ❒COMPLETE	Electronic recording of data is limited to billing & scheduling; data are retrieved according to diagnostic code in relation to billing and scheduling; these data are used to identify specific patient groupings. ❒ PARTIAL ❒ COMPLETE	An electronic data system includes identifiers and utilization data about children with special health care needs CSHCN; these data are used for monitoring, tracking, and for indicating levels of care complexity. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, an electronic data system is used to support the documentation of need, monitoring of clinical care, care plan and related coordination and the determination of outcomes (e.g. clinical, functional, satisfaction and cost outcomes). ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 5: Data Management: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#5.2 **Data Retrieval** **Capacity**	*PCP* retrieves patient data from paper records in response to outside agency requirements (e.g. *quality* standards, special projects, or *practice* improvements). ❒ PARTIAL ❒ COMPLETE	The *practice* retrieves data from paper records and electronic billing and scheduling for the support of significant office changes (e.g. staffing, or allocation of resources). ❒ PARTIAL ❒ COMPLETE	Data are retrieved from electronic records to identify and quantify populations and to track selected health indicators & outcomes. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, electronic data are produced and used to drive practice improvements & to measure *quality* against benchmarks; (those producing and using data practice confidentiality) ❒ PARTIAL ❒ COMPLETE
Comments				

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Domain 6: Quality Improvement/Change: For CSHCN and Their Families				
THEME:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
#6.1 *Quality* Standards (structures)	Quality standards for children with special health care needs (*CSHCN)* are imposed upon the *practice* by internal or external organizations. ❒ PARTIAL ❒COMPLETE	In addition to Level 1, an individual staff member participates on a committee for improving processes of care at the *practice* for *CSHCN*. This person communicates and promotes improvement goals to the whole practice. ❒ PARTIAL ❒ COMPLETE	The *practice* has its own systematic quality improvement mechanism for *CSHCN*; regular provider and staff meetings are used for input and discussions on how to improve care and treatment for this population. ❒ PARTIAL ❒ COMPLETE	In addition to Level 3, the *practice* actively utilizes quality improvement (QI) processes; staff and parents of *CSHCN* are supported to participate in these QI activities; resulting quality standards are integrated into the operations of the *practice*. ❒ PARTIAL ❒ COMPLETE
Comments				

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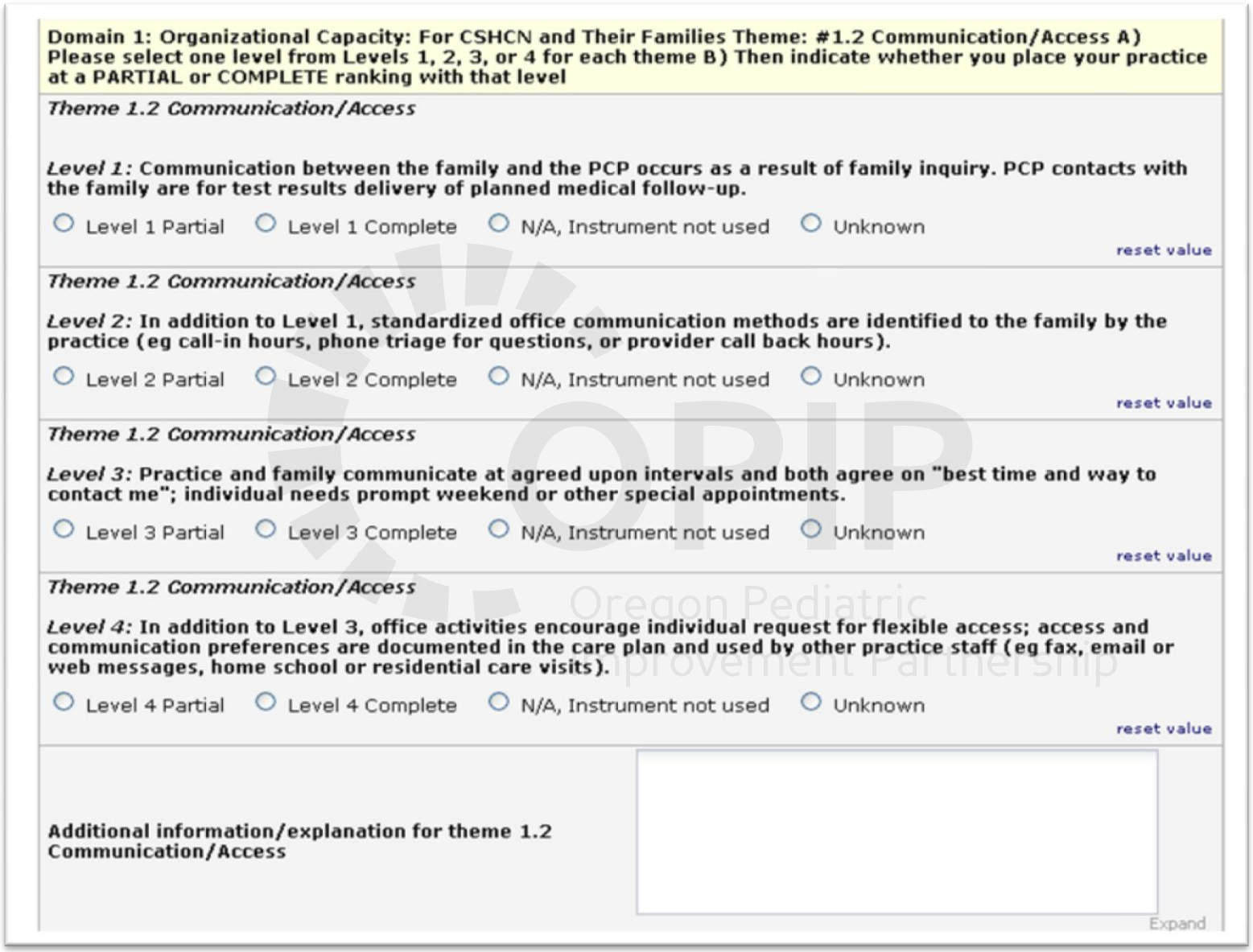
Below is an example of how the MHI: Revised Short Form will appear in REDCap:



Domain 1: Organizational Capacity: For CSHCN and Their Families Theme: #1.2 Communication/Access A) Please select one level from Levels 1, 2, 3, or 4 for each theme B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking with that level

Theme 1.2 Communication/Access

Level 1: **Communication between the family and the PCP occurs as a result of family inquiry. PCP contacts with the family are for test results delivery of planned medical follow-up.**

○ Level 1 Partial ○ Level 1 Complete ○ N/A, Instrument not used ○ Unknown

reset value

Theme 1.2 Communication/Access

Level 2: **In addition to Level 1, standardized office communication methods are identified to the family by the practice (eg call-in hours, phone triage for questions, or provider call back hours).**

○ Level 2 Partial ○ Level 2 Complete ○ N/A, Instrument not used ○ Unknown

reset value

Theme 1.2 Communication/Access

Level 3: **Practice and family communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt weekend or other special appointments.**

○ Level 3 Partial ○ Level 3 Complete ○ N/A, Instrument not used ○ Unknown

reset value

Theme 1.2 Communication/Access

Level 4: **In addition to Level 3, office activities encourage individual request for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (eg fax, email or web messages, home school or residential care visits).**

○ Level 4 Partial ○ Level 4 Complete ○ N/A, Instrument not used ○ Unknown

reset value

Additional information/explanation for theme 1.2 Communication/Access

Expand

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MODULE 4: The National Committee for Quality Assurance Patient-Centered Medical Home (NCQA PCMH) 2011 is set of standards used to systematically evaluate and recognize clinician practices functioning as medical homes. The NCQA PCMH 2011 standards reflect elements that make primary care successful. Primary care clinicians are often the first point of contact for an individual thus, patient access to care is an important issue. Clinicians must have a broad knowledge of many health care conditions and often follow their patients over years; thus, the quality of the clinician/patient relationship and the clinician's ability to track care over time are also important. Many primary care clinicians need to refer patients to specialists, making communication among providers important—and often challenging.

Note About NCQA PCMH 2011 versus 2008: This tool is anchored to the items that are in the NCQA PCMH 2011 standards. It is important that this version, and NOT the 2008 version, be used as there are a number of measures that are ONLY in the 2011 version that are integral to the T-CHIC measurement and evaluation efforts.

Note About NCQA PCMH Accreditation: For the purposes of T-CHIC, we are using the NCQA PCMH **2011** to collect baseline and evaluation measurement and only the item-level responses are needed.

- HOWEVER, significant documentation and instructions are provided in this tool for offices who may choose to, independently, submit their own data to accreditation by NCQA.
- For this process, significant documentation is required by NCQA to be provided to them. We have included notes about the documentation required in the tool to assist practices in maximizing their efforts should they be considering NCQA accreditation. This **documentation is NOT REQUIRED** for T-CHIC measurement purposes nor is applying for NCQA accreditation.
- A detailed description of the application process can be found on the NCQA PCMH 2011 website:
    - http://www.NCQA PCMH 2011.org/
    - https://inetshop01.pub.NCQA PCMH 2011.org/publications/product.asp?dept%5Fid=2&pf%5Fid=30002%2D150%2D11.

INSTRUCTIONS

The NCQA PCMH 2011 module is organized by six standards that align with the core components of primary care:

1. PCMH 1: Enhance Access and Continuity
2. PCMH 2: Identify and Manage Patient Populations
3. PCMH 3: Plan and Manage Care
4. PCMH 4: Provide Self-Care Support and Community Resources
5. PCMH 5: Track and Coordinate Care
6. PCMH 6: Measure and Improve Performance

Each standard contains several elements ranging from A to G (Note: not all standards contain this many elements).

Please read each element and select the answer that best describes your practice. Text boxes have been provided for responses that require additional information.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

> For all factors, the practice must provide their defined standards or policies with a date of implementation (***must be in effect at least 3 months***) **and** demonstrate they have monitored performance against the standards they have defined.

If you have specific questions about the terms/items in this tool please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

Note: In REDCap, when possible, survey item information will be been entered for you. This is noted in green below. Please review these items and correct any erroneous entries.

USAGE OF "IN PROGRESS" ANSWER OPTION

In an effort to better capture the important work that T-CHIC practices are doing, we would like to allow practices the opportunity to report that they are currently working on items that they have not yet achieved. We recognize that this work takes small tests of change with subpopulations or individual providers before full implementation. To better recognize that work, please read the instructions below on using an "In Progress" Designation.

Instructions for Answering NCQA Items:

- If processes have been in place for all patients and providers for at least 3 months per NCQA specifications, **answer "Yes"**.

- If processes **have not** been in place for all patients and providers for at least 3 months per NCQA specifications, BUT a practice is currently working on this process, **answer "In Progress"**.

- If processes **have not** been in place for all patients and providers for at least 3 months per NCQA specifications, **answer "No"**.

If you have specific questions about the "In Progress" answer option, please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

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1. Study ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A unique, assigned ID that allows for de-identification of practice Information)

2. Group ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A de-identified, assigned indicator to allow the grouping of analyses by state.)

3. Date of Completion

   _____/_____/_____

   (mm / dd / yyyy)

4. Was documentation used to complete the NCQA PCMH PPC-PCMH?
   *(**Note:** Please choose whether no documentation, limited documentation, or full NCQA documentation was used to complete this NCQA PCMH module. Please do not select "NA, instrument not used". If either limited or full NCQA documentation is used, please specify the NCQA PPC-PCMH version that was used.)*

5.

   ☐ No Documentation Used → **Go to Question 5**

   ☐ Limited Documentation Used, please specify below the NCQA PPC-PCMH version that was used → **Go to Question 4a.**

   ☐ Full NCQA PCMH documentation used, please specify below the NCQA PPC-PCMH version that was used → **Go to Question 4a.**

   ☐ NA, instrument not used → **Go to Question 5**

   ☐ Unknown → **Go to Question 5**

4a. Please specify the NCQA PPC-PCMH version that was used:
*(**Note:** answer only if Question 4 is "Limited Documentation" or "Full NCQA PCMH documentation.)*

   ☐ 2008

   ☐ 2011

6. Who completed Module 4 (NCQA PCMH 2011) of this Medical Home Office Report Measurement Tool?

   - ☐ Lead physician/physician extender - alone
   - ☐ Other staff member – alone, please specify below
   - ☐ Lead physician/physician extender with other staff member
   - ☐ Other combination/group, please specify below
   - ☐ Performance Enhancement Research Specialist (PERCS)
   - ☐ T-CHIC Study Staff (Jean Fisher, Jean Findley, etc)
   - ☐ Other, please specify below
   - ☐ N/A, instrument not used
   - ☐ Unknown

   If your response is "Other staff member – alone" <u>OR</u> "other combination/group OR other, a text box labeled 5a. will appear for you to enter additional information.

   5a. Other staff member – alone **<u>OR</u>** other combination/group **OR** other, please specify
   _____

   _____

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7. Title/position/role of person taking lead in completing Module 4 (NCQA PCMH 2011) of this Medical Home Office Report Measurement Tool.

PCMH 1: Enhance Access and Continuity

The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

Element 1A: Access During Office Hours

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

	Yes	In Progress	No	NA
1. Providing same-day appointments	☐	☐	☐	
2. Providing timely clinical advice by telephone during office hours	☐	☐	☐	
3. Providing timely clinical advice by secure electronic messages during office hours	☐	☐	☐	☐
4. Documenting clinical advice in the medical record.	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

If this PCMH element item only pertains to adult patients, please check here. ○ Yes

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation
Patients can access the clinician and care team for routine and urgent care needs by office visit, by telephone and through secure electronic messaging. Practice staff considers patient care needs and preferences when determining the urgency of patient requests for same-day access.

Factor 1*:* The practice reserves time for same-day appointments (also referred to as "open access," "advanced access" or "same-day scheduling") for routine and urgent care based on patient preference or triage. Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement.

An example of a measure of access is "third next available appointment," with an open-access goal of zero days (same-day availability). **Third next available appointment** measures the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on his/her clinician's schedule. The practice may measure availability for a variety of appointment types including urgent care, new patient physicals, routine exams and return-visit exams.

Factors 2 and 3: Clinicians return calls or respond to secure electronic messages in a timely manner, as defined by the practice to meet the clinical needs of the patient population. Factors 2 and 3 require the practice to define the time frame for a response, ***and*** monitor the timeliness of the response against the practice's standard.

Patients can seek and receive interactive clinical advice by telephone (factor 2) and secure electronic communication (factor 3) (e.g., electronic message, Web site) during office hours. **Interactive** means that questions are answered by an individual, not just a recorded message.

Factor 3 is NA if the practice does not have the capability to communicate electronically with patients.
Factor 4*:* Clinical advice must be documented in the patient

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: The practice has a documented process for staff to follow for scheduling same-day appointments ***and*** has a report that covers at least five days showing the availability of same-day appointments throughout the practice. The practice may provide a report showing the average third next available appointment.

Factor 2: The practice has a documented process for staff to follow for providing timely clinical advice by telephone (including the practice's definition of 'timely') *and* has a report summarizing its actual response times. The report may be system generated or collected based on at least five days of calls.

Factor 2 requires the practice to:

Define the time frame for a response, ***and***

Monitor the timeliness of the response against the practice's standard.

Factor 3: The practice has a documented process for staff to follow for providing timely clinical advice using a secure, interactive electronic system (including the practice's definition of 'timely') *and* has a report summarizing its actual response times. The report may be system generated or collected based on at least one week of electronic messages.

Factor 3 requires the practice to:

- Define the time frame for a response, ***and***
- Monitor the timeliness of the response against the practice's standard.

Factor 4: The practice has a documented process for staff to follow for entering phone and electronic message clinical advice in the patient record ***and*** provides at least three examples of clinical advice documented in a patient record ***or*** generates a report identifying how often advice is documented in the medical record. The report must provide the percentage of patients with clinical advice documented in the medical records of those patients who received clinical advice within ***a recent one- month period.***

- *Denominator* = Number of patients receiving clinical advice
- *Numerator* = Number of patients with clinical advice documented in the medical record

Below is an example of how the NCQA PCMH 2011 will appear in REDCap:

PCMH 1: Enhance Access and Continuity The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families. Element 1A: Access During Office Hours The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:	
Providing same day appointments	○ Yes ○ No reset value
Providing timely clinical advice by telephone during office hours	○ Yes ○ No reset value
Providing timely clinical advice by secure electronic messages during office hours	○ Yes ○ No ○ NA reset value NA if practice does not have capability to communicate electronically with pts.
Documenting clinical advice in the medical record	○ Yes ○ No reset value
Element 1B: After Hours Access The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:	
Routine and urgent appointments outside regular business hours	○ Yes ○ No reset value
Providing continuity of medical record information for care and advice when the office is not open	○ Yes ○ No reset value
Providing timely clinical advice by telephone when the office is not open	○ Yes ○ No reset value
Timely clinical advice using a secure, interactive electronic system when the office is not open	○ Yes ○ No ○ NA reset value NA if practice does not have capability to communicate electronically with pts
Documenting after-hours clinical advice in patient records	○ Yes ○ No reset value

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Element 1B: After-Hours Access

The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for:

	Yes	In Progress	No	NA
1. **Providing access to routine and urgent-care appointments outside regular business hours**	☐	☐	☐	
2. **Providing continuity of medical record information for care and advice when the office is not open**	☐	☐	☐	
3. Providing timely clinical advice by telephone when the office is not open	☐	☐	☐	
4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open	☐	☐	☐	☐
5. **Documenting after-hours clinical advice in patient records.**	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Patients can access the clinician and care team for routine and urgent care needs by office visit, by telephone and through secure electronic messaging. Practice staff considers patient care needs and preferences when determining the urgency of patient requests for same-day access.

Factor 1: The practice offers access to routine and non-routine care beyond regular business hours, such as early mornings, evenings or weekends. Appointment times are based on the needs of the patient population. If the practice does not provide care beyond regular office hours (e.g., a small practice with limited staffing), it may arrange for patients to receive care from other (non-ER) facilities or clinicians.

Factor 2: Patient clinical information is available to on-call staff and external facilities for after-hours care. Information may be provided by patients with individualized care plans or portable personal health records, or may be accomplished through access to an electronic health record (EHR). If care is provided by a facility that is not affiliated with the practice or does not have access to patient records, the practice makes provisions for patients to have an electronic or printed copy of a clinical summary of their medical record. Telephone consultation with the primary clinician or with a clinician with access to the patient's medical record is acceptable.

Factors 3 and 4: Patients can seek and receive interactive clinical advice by telephone (factor 3) and secure electronic communication (factor 4) (e.g., electronic message, Web site) when the office is closed. **Interactive** means that questions are answered by an individual, not just a recorded message.

The ability of patients to receive clinical advice from the practice or others, such as a service, designated by the practice when the office is not open reduces patient use of the emergency room and provides more patient-centered care.
Factor 4 is NA if the practice does not have the capability to communicate electronically with patients.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION
Factor 1: The practice has a documented process for staff to follow for arranging after-hours access with other practices or clinicians ***and*** provides a report showing after-hours availability ***or*** materials communicating practice hours. A process for arranging after-hours access is not required if the practice has regular extended hours.

Factor 2: The practice has a documented process for staff to follow for making medical record information available for after-hours care.

Factor 3: The practice has a documented process for staff to follow for providing timely clinical advice by telephone when the office is closed *and* has a report summarizing its actual response times. The report may be system generated or collected based on at least five days of calls.

Factor 3 requires the practice to:
- Define the time frame for a response, ***and***
- Monitor the timeliness of the response against the practice's standard.

Factor 4: The practice has a documented process for staff to follow for providing timely clinical advice using a secure interactive electronic system when the office is closed *and* has a report summarizing its actual response times. The report may be system generated or collected based on at least five days of electronic messages.

Factor 4 requires the practice to:
- Define the time frame for a response, ***and***
- Monitor the timeliness of the response against the practice's standard.

Factor 5: The practice has a documented process for staff to follow for documenting after-hours clinical advice in the patient record *and* has at least three examples of clinical advice documented in the patient record ***or*** generates a report identifying how often advice is documented in the medical record. The report must provide the percentage of patients with clinical advice documented in the medical record of those patients who received after-hours clinical advice within a recent *one-month period.*
- *Denominator* = Number of patients receiving after-hours clinical advice
- *Numerator* = Number of patients with after-hours clinical advice documented in the medical record.

Element 1C: Electronic Access

The practice provides the following information and services to patients and families through a secure electronic system.

	Yes	In Progress	No	NA
1. More than 50 percent of patients who request an electronic copy of their health information (including problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days	☐	☐	☐	☐
2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem lists, medication lists, and allergies) within four business days of when the information is available to the practice	☐	☐	☐	
3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days+	☐	☐	☐	
4. Two-way communication between patients/families and the practice	☐	☐	☐	
5. Request for appointments or prescription refills	☐	☐	☐	
6. Request for referrals or test results	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice please leave this blank and continue on to the next item.

Explanation:

Element C assesses the practice's ability to offer information and services to patients and their families via a secure electronic system. Patients should be able to view their medical record, access services and communicate with the health care team electronically. Practices with a Web site or patient portal should provide the URL.

Factor 1: More than 50 percent of patients (and others with legal authorization to the information) who request an electronic copy of their health information (including problem lists, diagnoses, diagnostic test results, medication lists, allergies) are given one within three business days. Factor 1 addresses the capabilities of the electronic system used by the practice; it does not address legal issues of access to medical record information, such as by guardians, foster parents or caregivers of pediatric patients, or teen privacy rights. If a practice has no requests from patients or families for an electronic copy of patient health information during the EHR reporting period the practice may respond N/A. If N/A is selected for Factor 1, the practice must provide an explanation.

Factor 2: Patients are provided timely electronic access to their health information (including lab results, problem lists, medication lists, and allergies). At least 10 percent of the practice's patients must have access to the practice's electronic system (e.g., be registered on the practice Web site or portal) within four business days of when the information is available to the practice.

Factor 3: An **electronic clinical summary** is a summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up. Federal meaningful use rules require that summaries be provided for more than 50 percent of office visits within three business days, either by secure electronic message or as a printed copy from the practice's electronic system. Patients may be notified that the information is available through a secure, interactive system such as a Web site or patient portal. If the summary is available electronically, the practice must provide the patient with a paper copy upon request.

Factor 4: The practice has a secure, interactive electronic system, such as a Web site, patient portal or a secure e-mail system, allowing two-way communication between patients/families and the practice.

Factor 5: Patients can use the secure electronic system (e.g., Web site or patient portal) to request appointments or medication refills.

Factor 6: Patients can use the secure electronic system (e.g., Web site or patient portal) to request referrals or test results.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–3: The practice provides a report based on a numerator and denominator for a recent 12 months of data in the electronic system. If the practice does not have 12 months of data (e.g., due to more recent system implementation), it may use a recent 3-month period for the calculation.

Factor 1: The practice provides a report showing the percentage of patients who got an electronic copy of health information within three business days of their request.

- *Denominator* = Number of patients who request an electronic copy of their electronic health information
- *Numerator* = Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

Factor 2: The practice provides a report showing the percentage of patients who were given electronic access to requested health information within four business days of it being available to the practice.

- *Denominator* = Number of patients seen by the practice
- *Numerator* = Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified HER technology) electronic access to their health information.

Factor 3: The practice provides a report showing the percentage of office visits for which electronically-generated clinical summaries were provided to patients within three business days.

- *Denominator* = Number of office visits
- *Numerator* = Number of office visits in the denominator for which patients were provided a clinical summary of their visit within three business days.

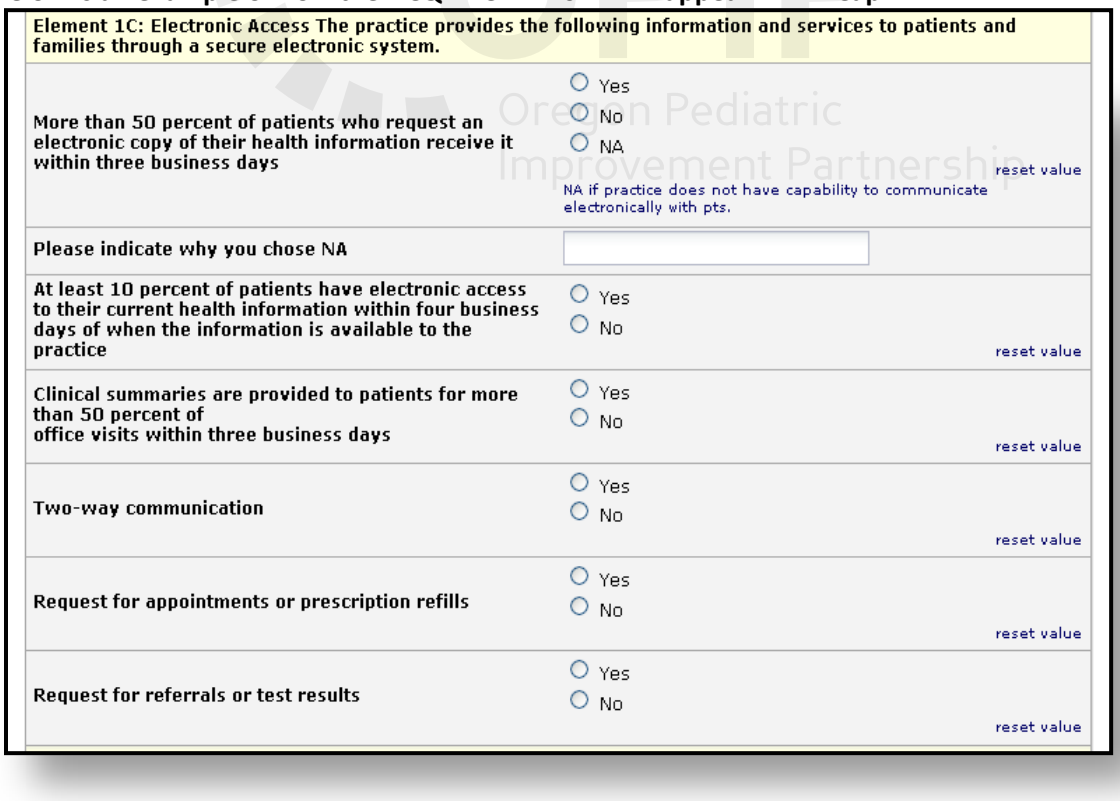
Factors 4–6: Require the practice to provide a screen shot demonstrating system capability.

Factor 4: The practice provides a screen shot of the secure two-way communication system demonstrating its implementation in the practice.

Factor 5: The practice provides a screen shot of a Web page where patients can request medication refills or appointments, demonstrating its implementation in the practice.

Factor 6: The practice provides a screen shot of a Web page where patients can request referrals or test results, demonstrating its implementation in the practice.

Below is an example of how the NCQA PCMH 2011 will appear in REDCap:



Element 1C: Electronic Access The practice provides the following information and services to patients and families through a secure electronic system.	
More than 50 percent of patients who request an electronic copy of their health information receive it within three business days	○ Yes ○ No ○ NA reset value NA if practice does not have capability to communicate electronically with pts.
Please indicate why you chose NA	
At least 10 percent of patients have electronic access to their current health information within four business days of when the information is available to the practice	○ Yes ○ No reset value
Clinical summaries are provided to patients for more than 50 percent of office visits within three business days	○ Yes ○ No reset value
Two-way communication	○ Yes ○ No reset value
Request for appointments or prescription refills	○ Yes ○ No reset value
Request for referrals or test results	○ Yes ○ No reset value

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Element 1D: Continuity

The practice provides continuity of care for patients/families by:

	Yes	In Progress	No
1. Expecting patients/families to select a personal clinician	☐	☐	☐
2. Documenting the patient's/family's choice of clinician	☐	☐	☐
3. Monitoring the percentage of patient visits with a selected clinician or team.	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation:

A **team** is a primary clinician and the associated clinical and support staff who work with the clinician. A team may also represent a medical residency group assigned under a supervising physician.

The practice provides continuity of care by allowing patients and their families to select a personal clinician who works with a defined health care team, and by documenting the selection. All practice staff are aware of a patient's personal clinician or team and work to accommodate visits and other communication. The practice monitors the proportion of patient visits with the designated clinician or team.

Note: *Solo practitioners should mark "yes" for each factor and indicate in the survey tool Comments/Text box that there is only one primary clinician in the practice.*

Factors 1 and 2: The practice notifies patients about the process for choosing a personal clinician and care team and supports the selection process by discussing the importance of having a clinician and care team responsible for coordinating care. The practice documents the patient/family's choice of clinician and practice team.

Factor 3: The practice monitors the percentage of patient visits that occur with the selected clinician and team.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: The practice has a documented process for patient/family selection of a personal clinician.

Factor 2: The practice has a screen shot from its electronic system, showing documentation of patient/family choice of clinician.

Factor 3: The practice has a report with at least one week of data, showing the total proportion of patient encounters that occurred with the selected personal clinician or team.

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Element 1E: Medical Home Responsibilities

The practice has a process and materials that it provides patients/families on the role of the medical home, which include the following.

	Yes	In Progress	No
1. The practice is responsible for coordinating patient care across multiple settings	☐	☐	☐
2. Instructions on obtaining care and clinical advice during office hours and when the office is closed	☐	☐	☐
3. The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice	☐	☐	☐
4. The care team gives the patient/family access to evidence-based care and self-management support	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation The practice has a process for giving patients/families information on the obligations of the medical home and the responsibilities of the patient and family as partners in care. Care team roles are explained to patients/families. The practice is encouraged to provide information in multiple formats to accommodate patient preference and language needs.

Factor 1: The practice is concerned about the range of a patient's health (i.e., "whole person" orientation, including behavioral health) and is responsible for coordinating care across settings.

Factor 2: The practice provides information about its office hours; where to seek after-hours care; and how to communicate with the personal clinician and team, including requesting and receiving clinical advice during and after business hours.

Factor 3: To effectively serve as a medical home, the practice must have comprehensive patient information such as medications; visits to specialists; medical history; health status; recent test results; self-care information; and data from recent hospitalizations, specialty care or ER visits.

Factor 4: Patients can expect evidence-based care from their clinician and team, as well as support for self-management of their health and health care.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

- The practice has a **process** for giving patients information and materials about the obligations of a medical home, ***and***
- Has **materials it provides to patients**, such as:
  - Patient brochure
  - Written statement for the patient and family
  - Link to online video
  - Web site
  - Patient compact (a written agreement between the patient/family and the practice specifying the role of the medical home practice and the patient/ family)

NCQA PCMH 2011 requests that the practice highlight, label or otherwise identify the information relevant to each factor in the documentation.

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Element 1F: Culturally and Linguistically Appropriate Services (CLAS)

The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

	Yes	In Progress	No	NA
1. Assessing the racial and ethnic 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	☐	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factors 1 and 2: The practice uses data to assess the cultural and linguistic needs of its population in order to address those needs adequately. This may be information collected by the practice directly from all patients or by using data that is available about the local community it serves.

Factor 3: Language services may include third-party interpretation services or multilingual staff. Under Title VI of the Civil Rights Act, clinicians who receive federal funds are responsible for providing language and communication services to their patients as required to meet clinical needs. Requiring a friend or family member to interpret for the patient does not meet the intent of this standard. Studies demonstrate that patients are less likely to be forthcoming with a family member present, and the family member may not be familiar with medical terminology. A third party tends to be more objective.

Factor 4: The practice identifies individual languages spoken by at least 5 percent of its patient population and makes materials available in those languages. The practice provides the forms that patients are expected to sign, complete or read for administrative or clinical needs to patients with limited English proficiency in the native language of the patient.

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Factor 4 is NA if the practice provides documentation that no single language (other than English) is spoken by 5 percent or more of its patient population. The practice must provide a written explanation for an NA response

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1 and 2: The practice provides a report showing its assessment of the racial, ethnic and language composition of its patient population.

Factor 3: The practice provides documentation the availability of interpretive services, or has a policy or statement that it uses bilingual staff. The policy or statement explains the practice's procedures when a patient needs assistance in a language not spoken by bilingual staff.

Factor 4: The practice provides or shows access to materials in languages other than English, a screenshot of a link to online materials or a Web site in languages other than English.

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Element 1G: The Practice Team

The practice uses a team to provide a range of patient care services by:

	Yes	In Progress	No
1. Defining roles for clinical and nonclinical team members	☐	☐	☐
2. Having regular team meetings or a structured communication process	☐	☐	☐
3. Using standing orders for services	☐	☐	☐
4. Training and assigning care teams to coordinate care for individual patients	☐	☐	☐
5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change	☐	☐	☐
6. Training and assigning care teams for patient population management	☐	☐	☐
7. Training and designating care team members in communication	☐	☐	☐
8. Involving care team staff in the practice's performance evaluation and quality improvement activities	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation Managing patient care is a team effort that involves clinical and nonclinical staff (e.g., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) interacting with patients and working to achieve stated objectives.

Factor 1: Job descriptions and responsibilities emphasize a team-based approach to care.

Factor 2: Team meetings may include daily huddles or review of daily schedules, with follow-up tasks. A **huddle** is a team meeting to discuss patients on the day's schedule. (Idaho Primary Care Association, http://idahopca.org/programs-services/patientcentered- medical-home-initiative/patient-centered-medical-home-resources). A structured communication process may include regular e-mail exchanges, tasks or messages about a patient in the medical record. Excellent communication and coordination among the members of the team has been found to be a critical feature of successful patient-centered practices.

Factor 3: Standing orders (e.g., testing protocols, defined triggers for prescription orders, medication refills, vaccinations, routine preventive services) may be clinician preapproved or may be executed without prior approval of the clinician as permitted by state law.

Factor 4: Care coordination may include obtaining test and referral results and communicating with community organizations, health plans, facilities and specialists.

Factor 5: Care team members are trained in evidence-based approaches to self management support, such as patient coaching and motivational interviewing.

Factor 6: Care team members are trained in the concept of population management and proactively addressing needs of patients and families served by the practice. **Population management** is assessing and managing the health needs of a patient population such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).

Factor 7: Care team members are trained on effective patient communication for all segments of the practice's patient population but particularly the vulnerable populations. **Vulnerable populations** are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co morbid conditions or who are at high risk for frequent hospitalizations or ER visits. Training may include information on health literacy, or other approaches to addressing communication needs.

Factor 8: The care team receives performance measurement and patient survey data and is given the opportunity to identify areas for improvement and establish methods for quality improvement. This can include regular participation in quality improvement meetings or action plan development.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1, 4–7: The practice provides staff position descriptions describing roles and functions.

Factor 2: The practice provides a description of its structured team communication processes that occur regularly *and* samples of meeting summaries, agendas or memos to staff.

Factor 3: The practice has written standing orders.

Factors 4–7: The practice has a description of its training process and training schedule or materials showing how staff is trained in each area identified in the factors.

Factor 8: The practice has a description of staff roles in the practice evaluation and improvement process, or minutes from team meetings showing staff involvement and describing staff roles. NCQA PCMH 2011 encourages the practice to highlight the information relevant to each factor in the documentation.

NCQA PCMH 2011 encourages the practice to highlight the information relevant to each factor in the documentation.

PCMH 2: Identify and Manage Patient Populations

The practice systematically records patient information and uses it for population management to support patient care.

Element 2A: Patient Information

The practice uses an electronic system that records the following as structured (searchable) data for more than 50 percent of its patients.

	Yes	In Progress	No	NA
1. Date of birth	☐	☐	☐	
2. Gender	☐	☐	☐	
3. Race	☐	☐	☐	
4. Ethnicity	☐	☐	☐	
5. Preferred language	☐	☐	☐	
6. Telephone numbers	☐	☐	☐	
7. E-mail address	☐	☐	☐	
8. Dates of previous clinical visits	☐	☐	☐	
9. Legal guardian/health care proxy	☐	☐	☐	
10. Primary caregiver	☐	☐	☐	
11. Presence of advance directives (NA for pediatric practices)	☐	☐	☐	☐
12. Health insurance information	☐	☐	☐	

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When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation:
The practice uses a practice management, EHR or other electronic system that collects and records patient information for factors 1-12 in searchable data fields. To meet this element the practice must generate a report showing the percentage of patients seen by the practice for whom data were entered. "Documentation in the medical record of "none", "no", "none" or "patient declined to provide information" counts toward the numerator. A data field should not be blank. Fields that have no data do not count.
Factor 1: The practice records patient date of birth.

Factor 2: The practice records patient gender.

Factors 3 and 4: The practice records race and ethnicity data, in addition to language and age, which contributes to its ability to understand its patient population. The practice may align race and ethnicity categories with those used by the Office of Management and Budget (OMB).

Factor 5: The practice documents the patient's preferred language. Patients are not required to discuss their language needs, but documentation helps identify patients who need interpretation and translation services. The practice must document that the patient declined to provide language information, that the patient's primary language is English or that the patient does not need language services. A blank field cannot be assumed to mean that the patient speaks English.

Factor 6: The patient's primary telephone number may be a mobile number.

Factor 7: The practice records patient e-mail addresses and should enter "none" in the field for patients who do not have an e-mail address or decline to provide one.

Factor 8: The practice enters dates of all office, electronic and telephone visits into the system. Visits (i.e., scheduled, structured encounters) are distinguished from electronic or telephone advice.

Factor 9: A **legal guardian** or **health care proxy** is an individual designated by the patient or family or by the courts to make health care decisions for the patient if the patient is unable to do so.

Factor 10: A **primary caregiver** provides day-to-day care for the patient and must receive instructions about care. Documentation of the primary caregiver should be in the health care record. The practice should enter "none" in the field if there is no caregiver.

Factor 11: There is documentation in the medical record that the patient/family gave the practice an advance directive (includes living wills, Physician Orders for Life Sustaining Treatment [POLST], durable power of attorney, health proxy). This factor may be marked "NA" if the practice sees only pediatric patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Factor 12: The practice has documentation of its patients' health insurance coverage (e.g., health plan name, Medicare, Medicaid, "none").

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–12: The practice provides reports from the electronic system showing the percentage of *all* patients for each populated data field. This is not limited to patients with the three identified important conditions or those in a disease-specific registry. The report contains each required data element to determine how many elements are consistently entered in the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Number of patients seen by the practice at least once during the reporting period (for factor 11, include only those who meet the age parameters)
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

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Element 2B: Clinical Data

The practice uses an electronic system to record the following as structured (searchable) data.

	Yes	In Progress	No	NA
1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients	☐	☐	☐	
2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients	☐	☐	☐	
3. Blood pressure, with the date of update for more than 50 percent of patients 2 years and older	☐	☐	☐	☐
4. Height for more than 50 percent of patients 2 years and older	☐	☐	☐	☐
5. Weight for more than 50 percent of patients 2 years and older	☐	☐	☐	☐
6. System calculates and displays BMI (NA for pediatric practices)	☐	☐	☐	☐
7. System plots and displays growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)	☐	☐	☐	☐
8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients (NA for pediatric practices if all patients <13 years)	☐	☐	☐	☐
9. List of prescription medications with the date of updates for more than 80 percent of patients	☐	☐	☐	

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When a "yes" response is entered in any item above, the following will appear:

If this PCMH element item only pertains to adult patients, please check here. ○ Yes

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation:

The practice collects clinical information on its patients through an EHR. It uses a system that can be searched for each factor and can create reports.

Factor 1: The patient's current and active problem list includes acute and chronic diagnoses.

Factor 2: Allergies (including medication, food or environmental allergies) and any associated reactions are recorded as structured data.

Factor 3: All blood pressure readings are documented and dated. Per the Stage 1 meaningful use requirement, this is applicable to patients 2 years and older. Practices *may* choose meet the NCQA PCMH 2011 requirement with an age definition of **3 years and older** if able to generate a report for this alternative age group.

Factors 4 and 5: Height and weight are documented and dated. This is applicable to patients 2 years and older. NA may be used for practices with no patients greater than 2 years. The practice must provide a written explanation for an NA response.

Factor 6: The practice demonstrates the ability of its electronic system to calculate and display BMI within the medical record. NA may be used for pediatric practices.
The practice must provide a written explanation for an NA response.

Factor 7: The practice demonstrates the capability of its electronic system to plot and display length, weight and head circumference on a growth chart for children younger than 2 years. Head circumference in children under 2 is a vital growth parameter that provides a guide to a child's health, development, nutritional status and response to treatment.

For patients 2–20 years, BMI is calculated using height and weight and plotted on the appropriate CDC BMI-for-age growth chart to obtain a percentile ranking and displayed within the medical record. Percentiles are the most commonly used indicator to assess size and growth patterns. NA may be used for practices with no pediatric patients. The practice must provide a written explanation for an NA response.

Factor 8*:* Data on smoking status and tobacco use are collected as a separate factor to emphasize its importance in relation to overall health. NA may be used if the practice has ***no*** patients 13 years and older. The practice must provide a written explanation for an NA response.

Factor 9: Current prescription medications prescribed by clinicians seen by the patient (including those outside the practice) and updates are recorded as structured data in the medical record. The practice indicates in the record if the patient is not prescribed any medication.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–5, 8, 9: The practice provides reports from the electronic system showing the percentage of *all* unique patients for each populated data field. This is not limited only to patients with the three identified important conditions or who are in a disease specific registry. The report contains each required data element to determine how many elements are consistently entered in the practice's electronic system.

This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Number of patients seen by the practice at least once during the reporting period (for factors 3, 4, 5 and 8; only those meeting the age parameters are included)
- *Numerator* = Number of patients in the denominator for whom the specified data are entered for each data element.

Factors 6 and 7: Screen shots demonstrating capability of the electronic system to calculate and display BMI (factor 6) and plot and display growth charts and BMI percentile (factor 7).

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Element 2C: Comprehensive Health Assessment

To understand the health risks and information needs of patients/ families, the practice conducts and documents a comprehensive health assessment that includes:

	Yes	In Progress	No	NA
1. Documentation of age- and gender-appropriate immunizations and screenings	☐	☐	☐	
2. Family/social/cultural characteristics	☐	☐	☐	
3. Communication needs	☐	☐	☐	
4. Medical history of patient and family	☐	☐	☐	
5. Advance care planning (NA for pediatric practices)	☐	☐	☐	☐
6. Behaviors affecting health	☐	☐	☐	
7. Patient and family mental health/substance abuse	☐	☐	☐	
8. Developmental screening using a standardized tool (NA for adult-only practices)	☐	☐	☐	☐
9. Depression screening for adults and adolescents using a standardized tool.	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

In addition to a physical assessment, a standardized, comprehensive assessment of a patient includes an examination of social and behavioral influences.

Factor 1: Specific age/gender-appropriate screenings and immunizations are not specified by NCQA PCMH 2011, but may be those identified by the U.S. Preventive Services Task Force (USPSTF) or the Centers for Medicare & Medicaid Services (CMS) in the Provider Quality Reporting System (PQRS), NCQA PCMH 2011's Child Health measures, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), preventive care and screenings for children and for women as recommended by the Health Resources and Services

Administration (HRSA) or other standardized preventive measures, including those identified in Bright Futures for pediatric patients.

Factor 2: The health assessment includes an evaluation of social and cultural needs, preferences, strengths and limitations. Examples of these characteristics can include family/household structure, support systems, household/environmental risk factors and patient/family concerns.

Factor 3: The practice identifies whether the patient has specific communication requirements (e.g., because of hearing or vision issues).

Factor 4: The practice obtains and documents the relevant medical history of its patients and their families.

Factor 5: **Advance care planning** refers to practice guidance and documentation of patient/family preferences for care at the end of life or for patients who are unable to speak for themselves. This may include discussing and documenting a plan of care with treatment options and preferences. Factor 5 applies primarily to adult populations and may be marked "NA" by practices that see only pediatric patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Factor 6: Assessment of risky and unhealthy behaviors should go beyond physical activity and smoking status. Assessment may include nutrition, oral health, dental care, familial behaviors, risky sexual behavior and secondhand smoke exposure. Unhealthy behaviors are often linked to the leading causes of death—heart disease, stroke, cancer, diabetes and injury. (CDC BRFSS)

Factor 7: The practice assesses whether the patient or the patient's family has any mental health conditions or substance abuse issues (e.g., stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).

Factor 8: For newborns through 3 years of age, periodic developmental screening is done using a standardized screening test. If there are no established risk factors or parental concerns, screens are done by 24 months. Factor 8 may be marked "NA" by practices that serve only adult patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Factor 9: The USPSTF recommends:

- **Adults:** Screening adults for depression when staff-assisted depression care support systems are in place to assure accurate diagnosis, effective treatment and follow-up.
- **Adolescents (12–18 years):** Screening for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–9: The practice provides a process showing how the information is consistently collected ***or*** a completed patient assessment (de-identified) of the factors documented during the health assessment. NCQA PCMH 2011 encourages practices to highlight or otherwise indicate the information in the documentation that meets each factor. Do not provide large portions of a medical record.

Element 2D: Use Data for Population Management

The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/ families and clinicians of services needed for:

	Yes	In Progress	No
1. At least three different preventive care services	☐	☐	☐
2. At least three different chronic care services	☐	☐	☐
3. Patients not recently seen by the practice	☐	☐	☐
4. Specific medications	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice demonstrates that it produces lists of patients needing preventive care and chronic care services, patients not seen recently and patients on specific medications. The practice uses the lists or report(s) (a *report may include multiple services needed*) to manage specific patient populations.

The practice shows how it uses reports to remind patients of needed services. For example, in addition to a report showing the number of patients eligible for mammograms, the practice must provide evidence or a brief statement describing how it reminds patients to get mammograms. The practice may use mail, telephone or e-mail to remind patients when services are due.

Factors 1 and 2 blend two meaningful use criteria in each factor.

- *Generate lists of patients:* Generate at least one report listing patients with a specific condition to use for quality improvement, reduction of disparities and outreach.
- *Send reminders:* More than 20 percent of all patients 65 years or older or 5 years or younger are sent an appropriate reminder for preventive or follow-up care.

Factor 1: The practice generates lists of patients and uses the lists to remind patients of at least three preventive care services needed appropriate to the patients' age or gender (e.g., well-child visits, pediatric screenings, immunizations, mammograms, fasting blood sugar, and stress test).

Factor 2: The practice generates lists of patients who need chronic care management services and uses the lists to remind patients of at least three chronic care services needed. Examples include diabetes care, coronary artery disease care, lab values outside normal range and post-hospitalization follow-up appointments. Examples for children include services related to chronic conditions such as asthma, ADHD, ADD, obesity and depression.

Factor 3: The practice generates lists of patients who may have been overlooked and who have not been seen recently. The practice may use its own criteria, such as a care management follow-up visit or an overdue periodic physical exam.

Factor 4: The practice generates lists of patients on specific medications; the lists may be used to manage patients who were prescribed medications with potentially harmful side effects, to identify patients who have been prescribed a brand name drug instead of a generic drug or to notify patients about a recall.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

The practice demonstrates that during the past year it proactively identified and provided outreach to patients in need of services (as described in each factor). Data provided from one or more health plans that account for at least 75 percent of the practice's patient population are acceptable.

Factors 1–4: For each factor, the practice provides:

- *Reports or lists* of patients needing services generated within the past 12 months. For factors 1 and 2, documentation must identify at least three different services.

and

- *Materials* showing how patients are notified of needed services (e.g., letters sent to patients, a script or description of phone reminders, screen shots of electronic notices).

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PCMH 3: Plan and Manage Care

The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.

Element 3A: Implement Evidence-Based Guidelines

The practice implements evidence-based guidelines through point-of-care reminders for patients with:

	Yes	In Progress	No
1. The first important condition	☐	☐	☐
2. The second important condition	☐	☐	☐
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice maintains continuous relationships with patients through care management processes based on evidence-based guidelines. A key to successful implementation of guidelines is to embed them in the practice's day-to-day operations (frequently referred to as clinical decision support) and by using registries that proactively identify and engage patients who are lacking important services (as in PCMH 2, Element D).

The practice analyzes its entire population to determine the required important conditions, which may be chronic or recurring conditions such as COPD, hypertension, hyperlipidemia, HIV/AIDS, asthma, diabetes or congestive heart failure.

When selecting conditions, practices should consider the following:

- Diagnoses and risk factors prevalent in patients seen by the practice (data from PCMH 2, Elements B and C)
- The importance of care management and self-management support in reducing complications

- The availability of evidence-based clinical guidelines
- Patients with the conditions selected in factors 1–3 will be used for the medical record review required in PCMH 3, Elements C and D, and in PCMH 4, Element A

Pediatric populations

Relevant conditions may include, but are not limited to, asthma, obesity, eczema, allergic rhinitis, pharyngitis, bronchiolitis, sinusitis, otitis media and urinary tract infection. Well-child care is also an acceptable condition in pediatrics because there are established, comprehensive guidelines for children that include a variety of care needs, such as regular developmental assessments, anticipatory guidance and preventive care services. Well-child care should be specified by age group and may only be used as one important condition.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

The practice provides the following:

- Lists the three important conditions
- Provides the name and source of evidence-based guidelines for each condition
- Demonstrates how the guidelines for each condition are implemented in patient care, using chart tools, screen shots or workflow organizers.
- Examples of guideline implementation, organizers, flow sheets or templates based on condition-specific guidelines enabling the practice to develop treatment plans and document patient status and progress. These tools are used by the practice to manage patient care. Templates of the tools may be provided for documentation.
- Electronic system organizer (e.g., registry, EHR, other system) screenshots showing templates for treatment plans and documenting progress.

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Element 3B: Identify High-Risk Patients

To identify high-risk or complex patients, the practice:

	Yes	In Progress	No
1. Establishes criteria and a systematic process to identify high-risk or complex patients	☐	☐	☐
2. Determines the percentage of high-risk or complex patients in its population.	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factor 1: The practice has specific criteria and has a process based on these criteria to identify patients with complex or high-risk medical conditions for whole-person care planning and management.

The criteria for identifying complex or high-risk patients should come from a profile of resource use and risk in the practice's population and may include the following, or a combination of the following.

- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care (e.g., two or more visits in the last six months)
- Frequent hospitalizations (i.e., two or more in last year)
- Multiple co-morbidities, including mental health
- Noncompliance with prescribed treatment/medications
- Terminal illness
- Psychosocial status, lack of social or financial support that impedes ability for care
- Advanced age, with frailty
- Multiple risk factors

Pediatric populations

- Practices may identify children and youth with special health care needs who are defined by the U.S. Department of Health and Human Services Maternal and Child Health Bureau (MCHB) as children "who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who require health and related services of a type or amount beyond that required generally." (Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, American Academy of Pediatrics, 3rd Edition, 2008, p. 18.)

• Additional care management guidelines for children and youth with special needs are included in the following publication: Caring for Children Who Have Special Health-care Needs: A Practical Guide for the Primary Care Practitioner. Matthew D. Sadof and Beverly L. Nazarian, *Pediatr. Rev.* 2007;28;e36-e42 http://pedsinreview.aappublications.org/cgi/content/full/28/7/e36

The practice may identify patients through a billing or practice management system or electronic medical record; through key staff members; or through profiling performed by a health plan, if profiles provided by the plan(s) represent at least 75 percent of the patient population.

Note: *A sample of the patients identified as high risk or complex will be included in the medical record review required for Elements C and D, and for PCMH 4, Element A.*

Factor 2: While this factor asks the practice to calculate a percent, the purpose is not to evaluate the actual percent which may be small, but rather for the practice to identify its high risk patients in comparison to the rest of its population of patients.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: The practice provides a process and criteria used to identify patients.
Factor 2: The practice provides a report that shows the number and percentage of its total patient population identified as high risk or complex. This factor calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage.

- *Denominator* = Total number of patients in the practice
- *Numerator* = Patients identified in the denominator as high risk or complex

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Element 3C: Care Management

The care team performs the following for at least 75 percent of the patients identified in Elements A and B.

	Yes	In Progress	No	NA	Enter Percent
1. Conducts pre-visit preparations	☐	☐	☐		
2. Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit	☐	☐	☐		
3. Gives the patient/family a written plan of care	☐	☐	☐		
4. Assesses and addresses barriers when the patient has not met treatment goals	☐	☐	☐		
5. Gives the patient/family a clinical summary at each relevant visit	☐	☐	☐		
6. Identifies patients/families who might benefit from additional care management support	☐	☐	☐		
7. Follows up with patients/families who have not kept important appointments (If the patient record shows that the patient has kept important appointments the practice may respond NA for this patient.)	☐	☐	☐	☐	

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When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

While patients may be identified for care management by diagnosis or condition, the emphasis of the care must be on the whole person over time and on managing all of the patient's care needs. The practice adopts evidence-based guidelines and uses them to plan and manage patient care.

Factor 1: The practice asks patients (e.g., by letter or e-mail) to complete required paperwork before a scheduled visit, in addition to lab tests, imaging tests or referral visits. The practice reviews test results before the visit. This process can be part of the team daily huddle or a protocol, procedure or checklist.

Factor 2: Individualized care plans developed in collaboration with the patient/family address the patient's care needs, the responsibilities of the medical home and of specialists to whom the patient is referred and the role of community services and support, if appropriate. Care plans must include treatment goals and may be based on a template.

At each relevant visit, the clinician uses indicators from evidence-based practice guidelines, such as lab test results (e.g., HbA1c), patient symptoms (e.g., depression symptoms), blood pressure or asthma functional score, to determine patient progress with the care plan and treatment goals, or documents deviation from established guidelines and includes the rationale. If there are no changes in the care plan at relevant visits, the practice must document this in the medical record.

Relevant visits are determined by the practice and the clinician, but should be with regard to:

- Important or chronic conditions, including well-child visits for practices with pediatric patients
- Visits that result in a change in treatment plan or goals
- Additional instructions or information for the patient/family
- Visits associated with transitions of care.

Pediatric practices that use well-child visits as an important condition may use child development markers specified by the American Academy of Pediatrics to assess progress.

Factor 3: The practice gives the patient and/or family a care plan tailored for the patient's use at home and to the patient's understanding.

Factor 4: The clinician or care team assesses or talks with the patient/family to determine reasons for limited progress toward treatment goals, and to help the patient/family address barriers (e.g., patient's lack of understanding or motivation, financial need, insurance issues, adverse effects of medication or other treatment or transportation problems). The clinician or care team changes the treatment plan or adds treatment, if appropriate. A completed social history is acceptable as documentation that the clinician or care team has assessed the patient's progress and thus is meeting treatment goals. The practice may respond NA for this patient.

Factor 5: The practice provides a written clinical summary at relevant office visits. Relevant visits are determined by the practice and the clinician but be with regard to:

- Important or chronic conditions, including well-child care visits for practices with pediatric patients
- Visits that result in a change in treatment plan or goals
- Additional instructions or information for the patient or family.

Factor 6: The practice assesses and, when appropriate, refers patients to other resources (external or internal) for additional care management support, such as disease management (DM) programs or case management programs.

Factor 7: The practice follows up with patients who have not kept important appointments, such as for rechecks, preventive care or post-hospitalization. Systematic tracking of important appointments that

patients have kept meets the intent of this factor. If the patient record shows that the patient has kept important appointments the practice may respond NA for this patient.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

The practice provides reports from an electronic system or uses the Record Review Workbook, showing each required data element, to determine the number of data elements consistently entered in the practice's medical records.

This element calls for calculation of a percentage that 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 systems for the important conditions identified in Elements 3A and 3B. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients with important conditions and patients identified as high-risk or complex who had at least one visit related to the important condition in a recent three month period
- *Numerator* = Number of patients identified in the denominator for whom each item is entered in the medical record

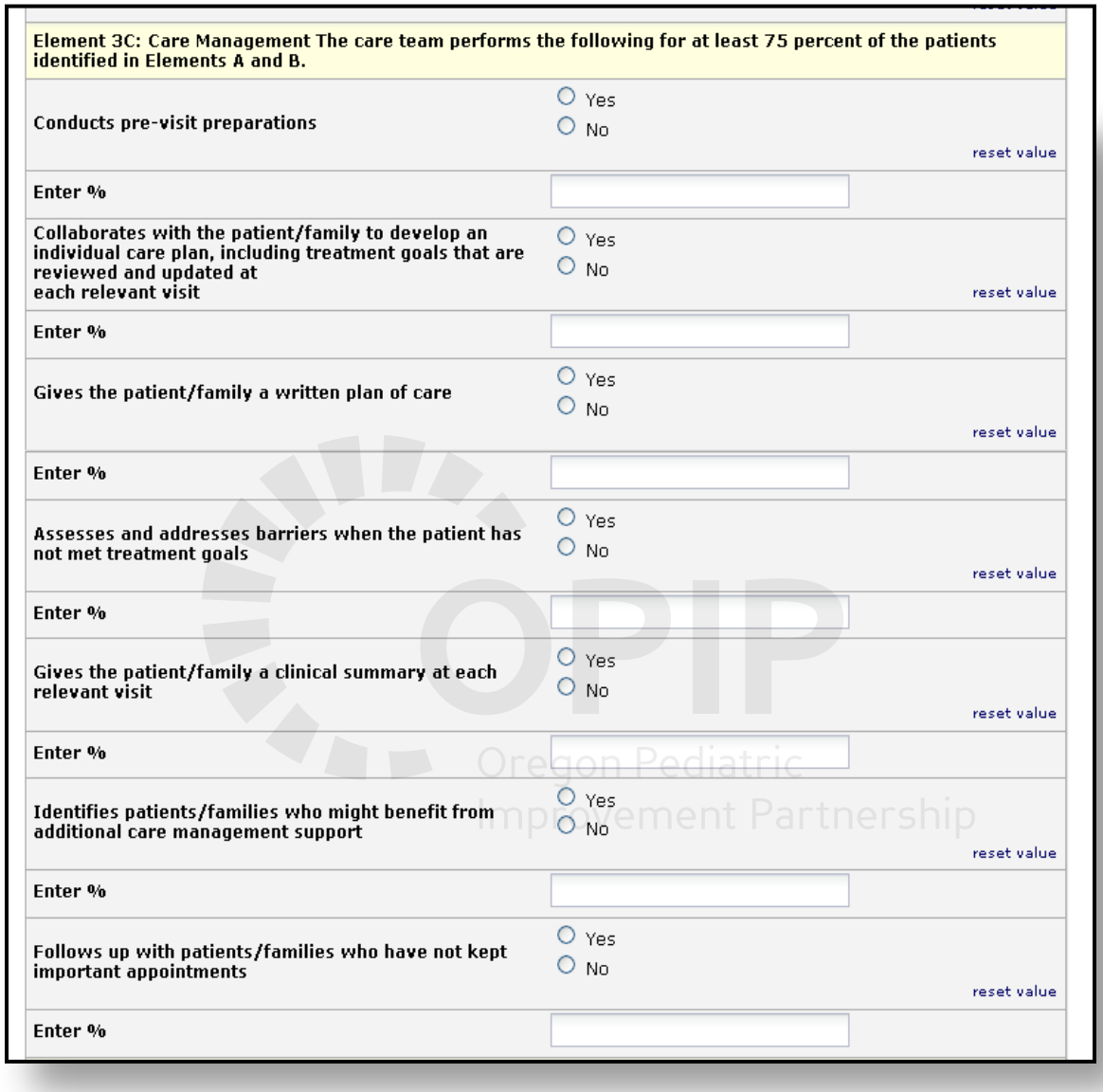
Method 2
Review a sample of medical records using the sampling method in NCQA PCMH 2011's Record Review Workbook. The practice must use the instructions in the Record Review Workbook to choose a sample of relevant patients and check for the relevant items.

Note: to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's important conditions and those identified as high risk or complex.

- *Denominator* = The sample of patient medical records using NCQA PCMH 2011's sampling method in the Record Review Workbook Instructions
- *Numerator* = The patients from the medical record review for whom items are entered

Note: *A patient may fall into more than one category (across the three conditions and the definition of "high risk" or "complex"), but each patient is counted only once. Factors must be successfully addressed for all conditions for the practice to respond "Yes" for each patient.*

Below is an example of how the NCQA PCMH 2011 will appear in REDCap:



Element 3C: Care Management The care team performs the following for at least 75 percent of the patients identified in Elements A and B.	
Conducts pre-visit preparations	○ Yes ○ No reset value
Enter %	
Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit	○ Yes ○ No reset value
Enter %	
Gives the patient/family a written plan of care	○ Yes ○ No reset value
Enter %	
Assesses and addresses barriers when the patient has not met treatment goals	○ Yes ○ No reset value
Enter %	
Gives the patient/family a clinical summary at each relevant visit	○ Yes ○ No reset value
Enter %	
Identifies patients/families who might benefit from additional care management support	○ Yes ○ No reset value
Enter %	
Follows up with patients/families who have not kept important appointments	○ Yes ○ No reset value
Enter %	

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Element 3D: Medication Management

The practice manages medications in the following ways.

	Yes	In Progress	No	Enter Percent
1. Reviews and reconciles medications with patients/families for more than 50 percent of care transitions	☐	☐	☐	
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions	☐	☐	☐	
3. Provides information about new prescriptions to more than 80 percent of patients/families	☐	☐	☐	
4. Assesses patient/family understanding of medications for more than 50 percent of patients with date of assessment	☐	☐	☐	
5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients with date of assessment	☐	☐	☐	
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families, with the date of updates	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

If this PCMH element item only pertains to adult patients, please check here. ○ Yes

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factors 1 and 2: It is important for the practice to review and document in the medical record all prescribed medications a patient is taking. The practice reviews and reconciles medications following visits to specialists, as well as ER visits and hospitalizations. Medication review and reconciliation should occur at transitions of care and at relevant visits, at least annually. The practice may define "relevant visit."

Maintaining a current list of a patient's medications and resolving any conflicts with medications reduces the possibility of duplicate medications, medication errors or adverse drug events. Having a process for medication reconciliation is essential for patient safety.

Factor 3: The practice provides patients/families with information about new medications, including potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it.

Factor 4: The practice assesses the patient's understanding of the information about the medication.

Factor 5: The practice asks the patient about problems or difficulty taking the medication and side effects; whether the patient is taking the medication as prescribed and if the patient is not taking the medication, possible reasons.

Factor 6: It is important that at least annually, the practice reviews and documents in the medical record that the patient is taking over-the-counter (OTC) medications, herbal therapies and supplements, to prevent

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

The practice provides reports from an electronic system or uses the Record Review Workbook, showing each required data element, to determine the number of data elements consistently entered in the practice's electronic system.

This element calls for calculation of a percentage that 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 systems for the important conditions identified in Elements 3A and 3B. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients with important conditions and patients identified as high-risk or complex who had at least one visit related to the important condition in a recent three month period
- *Numerator* = Number of patients identified in the denominator for whom each item is entered in the medical record

Method 2
Review a sample of medical records using the sampling method in NCQA PCMH 2011's Record Review Workbook. The practice must use the instructions in the Record Review Workbook to choose a sample of relevant patients and 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 and those identified as high risk or complex.

- *Denominator* = The sample of patient medical records using NCQA PCMH 2011's sampling method in the Record Review Workbook Instructions
- *Numerator* = The patients from the medical record review for whom *items* are entered

Not Applicable is an option in the Record Review Workbook drop-down menu for each factor in this element and may be used for patients who have not been prescribed any medications.

Note: *A patient may fall into more than one category (across the three conditions and the definition of "high risk" or "complex"), but each patient is counted only once. Factors must be successfully addressed for all conditions for the practice to respond "Yes."*

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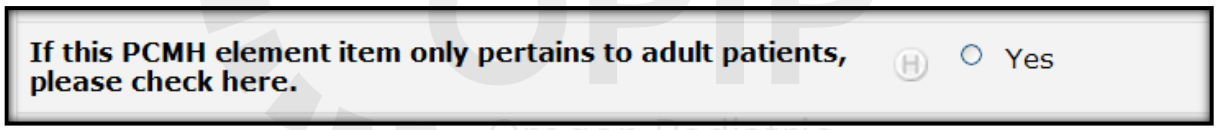
Element 3E: Use Electronic Prescribing

The practice uses an electronic prescription system with the following capabilities.

	Yes	In Progress	No	NA
1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies	☐	☐	☐	
2. Generates at least 75 percent of eligible prescriptions	☐	☐	☐	
3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list	☐	☐	☐	☐
4. Performs patient-specific checks for drug-drug and drug-allergy interactions+	☐	☐	☐	
5. Alerts prescribers to generic alternatives	☐	☐	☐	
6. Alerts prescribers to formulary status	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:



- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factor 1: The electronic prescribing system generates and transmits at least 40 percent of eligible prescriptions directly to the pharmacy. Eligible prescriptions exclude prescriptions that are not allowed by law to be electronically conveyed to pharmacies (e.g., controlled substances).

Factor 2: At least 75 percent of eligible prescriptions are generated electronically, including new prescriptions and renewals which requires the practice to produce a denominator that encompasses the total number of prescriptions issued (by hand, by phone and electronically). If the practice is not able to produce such a report, it may, instead, provide 1) the practice's prescribing process/policy including how the practice avoids the use of hand-written prescriptions and 2) information on the number of electronic prescriptions issued **and** total number of patients and 3) an explanation of how it represents at least "75 percent" of the total prescription volume.

Factors 1 and 2 distinguish between generating prescriptions electronically and generating them *and* transmitting them electronically. Practices may be able to create and produce prescriptions electronically without being able to transmit them to pharmacies.

Factor 3: The practice's electronic prescribing system is integral to patient records, allowing it to view patient diagnoses, patient medications, enter new medications or make changes and identify documented allergies. The practice uses the electronic prescribing system to enter medications prescribed to its patients. If a practice writes fewer than 100 prescriptions during the reporting period the response in the survey tool may be NA. The practice must provide a written explanation for an NA response. The practice must enter the number of prescriptions written during the reporting period in the survey tool or a linked document to attest to exclusion from this requirement.

Factor 4: When a new prescription request is entered, the practice's electronic prescribing system alerts the clinician to potentially harmful interactions between drugs or to patient allergy to a drug. **Patient-specific information** is related or linked to a specific patient.

Factor 5: The system alerts the clinician to cost-effective, generic options.

Factor 6: The system connects with or downloads the formulary for the patient's health plan to identify covered drugs and the copayment tier, if applicable.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: The practice provides reports from the electronic system. This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Eligible prescriptions written by the practice
- *Numerator* = Eligible prescriptions generated **and** transmitted with the practice's electronic prescribing system

Factor 2: The practice provides reports from the electronic system.
This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Eligible prescriptions written by the practice
- *Numerator* = Eligible prescriptions generated by the practice using the practice's electronic prescribing system

Factor 2 alternate documentation
The practice provides:

- Prescribing process/policy including how the practice ensures the avoidance of writing hand-written prescriptions

and

• Report showing the total number of patients seen in the past 12 months (or a recent 3-month period if the practice does not have 12 months of electronic data) and the number of eligible prescriptions generate by the practice using the electronic prescribing system during the same time period

and

• Explanation of how this calculation meets the 75% requirement

Factor 3: The practice provides reports from the electronic system.
This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

• *Denominator* = Patients in the practice's system with at least one medication in their medication list
• *Numerator* = Number of patients in the denominator with at least one medication entered directly into the medical record using the practice's integrated electronic prescribing system

Factors 4–6: The practice provides reports from the electronic system or screen shots demonstrating the system's capabilities.

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PCMH 4: Provide Self-Care Support and Community Resources

The practice acts to improve patients' ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support.

Element 4A: Support Self-Care Process

The practice conducts activities to support patients/families in self management:

	Yes	In Progress	No	Enter Percent
1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self management	☐	☐	☐	
2. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients, if appropriate	☐	☐	☐	
3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families	☐	☐	☐	
4. Documents self-management abilities for at least 50 percent of patients/families	☐	☐	☐	
5. Provides self-management tools to record self-care results for at least 50 percent of patients/families	☐	☐	☐	
6. Counsels at least 50 percent of patients/families to adopt healthy behaviors	☐	☐	☐	

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When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice provides patients with self-management support and tools beyond the counseling or guidance typically provided during an office visit, and provide or refers patients to self-management

programs or classes. Programs may be offered through community agencies, a health plan or a patient's employer.

Factor 1: Educational programs and resources may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, Web site links and pamphlets, as well as community resources (e.g., programs, support groups). Based on the practice's assessment of languages spoken by its patients (PCMH 2, Element A), materials in languages other than English should be available for patients/families, if appropriate

Patients/families may be referred to resources outside the practice, with consideration that resources may not be covered by health insurance. Self-management programs may include asthma education, diabetes education and other classes or groups as well as referrals to community resources for the uninsured and underinsured or for transportation assistance to medical appointments for patients.

Factor 2: The practice uses certified EHR to identify patient-specific educational resources and provides these resources to at least 10 percent of its patients, if appropriate.

CMS states, "Resources are identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient." Patients may be identified as candidates for patient specific educational resources through the patient's problem list, medication list, or laboratory test results. The practice uses certified EHR technology to suggest patient specific educational resources but the clinician makes the final decision on the usefulness and relevance to a specific patient."

Factor 3: The practice works with patients to develop a self-care plan that addresses a patient's condition and includes goals *and* a way to monitor self-care. NCQA PCMH 2011 expects the practice to have documentation that it provides written self-care plans to patients, families or caregivers. One example for pediatric practices is an asthma action plan. Self-management for pediatric practices may involve anticipatory guidance focusing on parent management of breastfeeding, eating, sleeping or activity patterns. Research supports the importance of practices developing a self-care plan in collaboration with patients that may be used by patients and families to manage care at home.

If the patient is meeting treatment goals, documentation could be that the patient is meeting treatment goals with documentation that the patient was instructed to maintain the current self-care plan.

Factor 4: Patients and families who feel they can manage their condition, learn needed self-care skills or adhere to treatment goals will have greater success. Practices may use motivational interviewing to assess patient readiness to change and self management abilities, including questionnaires and self-assessment forms. The purpose of assessing self-management abilities is that the practice can adjust self management plans to fit patient/family capabilities and resources.

Factor 5: Self-management tools enable patients to collect health information at home that can be discussed with the clinician. For example, a practice gives its hypertensive patients a form or another systematic method of documenting daily blood pressure readings, along with information about blood pressure measurement and instructions for taking a reading. Patients can track their progress and potentially adjust the treatment or their behavior. For pediatric practices, patients with asthma may be asked to monitor peak flows and the self-management plan offers instructions for how to adjust medications accordingly.

Factor 6: The practice provides evidence-based counseling (e.g., coaching, motivational interviewing) to patients for adopting healthy behaviors associated with disease risk factors (e.g., tobacco use, nutrition, exercise and activity level, alcohol use).

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

For all factors, the practice provides a report from an electronic system or uses the Record Review Workbook.

This element calls for calculation of a percentage that 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 systems for the important conditions identified in Elements 3A and 3B. The practice may use this method if it can determine a denominator as described below.

- *Denominator* = Total number of patients with important conditions and patients identified as high-risk or complex who had at least one visit related to the important condition in a recent three month period
- *Numerator* = Number of patients identified in the denominator for whom each item is entered in the medical record

Method 2
Review a sample of medical records using the sampling method in NCQA PCMH 2011's Record Review Workbook. The practice must use the instructions in the Record Review Workbook to choose a sample of relevant patients and 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 and those identified as high risk or complex.

- *Denominator* = The sample of patient medical records using NCQA PCMH 2011's sampling method in the Record Review Workbook Instructions
- *Numerator* = The patients from the medical record review for whom each activity is documented

Note: *A patient may fall into more than one category (across the three conditions and the definition of "high risk" or "complex"), but each patient is counted only once.*

Element 4B: Provide Referrals to Community Resources

The practice supports patients/families that need access to community resources:

	Yes	In Progress	No
1. Maintains a current resource list on five topics or key community service areas of importance to the patient population	☐	☐	☐
2. Tracks referrals provided to patients/families	☐	☐	☐
3. Arranges or provides treatment for mental health and substance abuse disorders	☐	☐	☐
4. Offers opportunities for health education programs (such as group classes and peer support.)	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

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Explanation

Factor 1: The key resource list is specific to the needs of *the practice's population*— **not specific to patients with important conditions**—and includes programs and services to help patients in self-care or give the patient population access to care related to at least five topics or key community service areas of importance, which may include:

- Smoking cessation
- Weight management (under- and overweight)
- Exercise/physical activity
- Nutrition
- Parenting
- Dental
- Other, such as:
  - Transportation to medical appointments
  - Noncommercial health insurance options
  - Obtaining prescription medications
  - Falls prevention
  - Meal support
  - Hospice
  - Respite care

- Child development
- Immunization information
- Child care,
- Breastfeeding

Although the practice may provide one or more services, it must also identify services or agencies available in the community. The intent of the element is for the practice to connect patients with available community resources.

Factor 2: The practice tracks frequency and types of referrals to agencies to evaluate whether it has identified sufficient and appropriate resources for its population over time.

Factor 3: The practice provides treatment or identifies a treatment provider and helps patients get care for mental health and substance abuse problems

Factor 4: The practice provides or makes available health education classes that may include alternative approaches such as peer-led discussion groups or shared medical appointments. In a **shared medical appointment** or **group visit,** multiple patients meet in a group setting for follow-up or routine care. These types of appointments may offer access to a multidisciplinary care team and allow patients to interact with and learn from each other.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: The practice has a list of community services or agencies with specified categories (e.g., smoking cessation programs).

Factor 2: The practice has a log or report showing referral tracking over a minimum period of one month.

Factors 3 and 4: The practice has a documented process **and** a sample of available resources.

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PCMH 5: Track and Coordinate Care

The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

Element A: Test Tracking and Follow-Up

The practice has a documented process for and demonstrates that it:

	Yes	In Progress	No	NA
1. Tracks lab tests until results are available, flagging and following up on overdue results	☐	☐	☐	
2. Tracks imaging tests until results are available, flagging and following up on overdue results	☐	☐	☐	
3. Flags abnormal lab results, bringing them to the attention of the clinician	☐	☐	☐	
4. Flags abnormal imaging results, bringing them to the attention of the clinician	☐	☐	☐	
5. Notifies patients/families of normal and abnormal lab and imaging test results	☐	☐	☐	
6. Follows up with inpatient facilities on newborn hearing and blood-spot screening (NA for adults)	☐	☐	☐	☐
7. Electronically communicates with labs to order tests and retrieve results	☐	☐	☐	
8. Electronically communicates with facilities to order and retrieve imaging results	☐	☐	☐	
9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in medical records	☐	☐	☐	☐
10. Electronically incorporates imaging test results into medical records.	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

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Explanation
Systematic monitoring is important to ensure that needed tests are performed and that results are acted on when they indicate a need for action. The practice routinely uses a manual or electronic system to order, track and follow up on test results. The report must reflect a minimum of 1 week of tests ordered by the practice

Factors 1 and 2: The practice tracks the majority of lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. **Flagging** is a systematic method of drawing attention to results that have not been received by the practice. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center and, if necessary, the patient, to determine why results are overdue. The expected time that results are made available to the practice varies by test and is at the discretion of the practice. Ineffective management of laboratory and imaging test results can result in less than optimal care and may compromise patient safety. Thus, .

Factors 3 and 4: Abnormal results of lab or imaging tests are flagged or highlighted and brought to the attention of the clinician to ensure timely follow-up with the patient/family.

Factor 5: The practice gives normal and abnormal results to patients in a timely manner (defined by the practice). There must be evidence that the practice proactively notifies patients of normal and abnormal results. Filing the report in the medical record for a patient's next office visit does not meet the intent of the factor.

Factor 6: The practice follows up with the hospital or state health department if screening results are not received. Most states mandate that birthing facilities perform a newborn blood-spot screening for a number of conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. The practice may respond NA in adult-only practices. The practice must provide a written explanation for an NA response.

Factors 7 and 8: Lab and imaging tests are ordered and retrieved electronically from testing facilities.

Factor 9: Lab test results are electronically integrated into the electronic system in the patient's medical record rather than requiring a look-up in a separate system and manual data entry into the electronic medical record.

CMS provides the following additional information: "If the practice orders no lab tests whose results are in a positive or negative or numeric format during the reporting period an NA response may be entered." The practice must provide a written explanation for an NA response.

Factor 10: Imaging results which include a written report and may include the images are electronically integrated into the medial record rather than requiring a look-up in a separate system and manual data entry into the electronic medical record. A scanned PDF of imaging results in the medical record, which allows the practice to retrieve and review the image, is acceptable.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–8, 10: The practice has a written process or procedure for staff *and* an example of how the process is met for each factor.

Factor 9: The practice provides reports from the electronic system. This element calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

- *Denominator* = Number of lab tests ordered during the reporting period with results expressed in a positive or negative affirmation or as a number
- *Numerator* = Number of lab tests whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.

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Element 5B: Referral Tracking and Follow-Up

The practice coordinates referrals by:

	Yes	In Progress	No	NA
1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information	☐	☐	☐	
2. Tracking the status of referrals, including required timing for receiving a specialist's report	☐	☐	☐	
3. Following up to obtain a specialist's report	☐	☐	☐	
4. Establishing and documenting agreements with specialists in the medical record if co-management is needed	☐	☐	☐	
5. Asking patients/families about self-referrals and requesting reports from clinicians	☐	☐	☐	
6. Demonstrating the capability for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians	☐	☐	☐	
7. Providing an electronic summary of the care record to another provider for more than 50 percent of referrals.	☐	☐	☐	☐

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When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factor 1: Information included in the referral communication to the specialist includes:

- Reason for and urgency of the referral
- Relevant clinical information (e.g., patient's family and social history, clinical findings and current treatment)
- General purpose of the referral (e.g., consultative, transfer of care, co management) and necessary follow-up communication or information.

Factor 2: The referral tracking system includes the date when the referral was initiated and the timing indicated for receiving the report. Screen shots of a patient record do not meet the requirement. Documentation requires a paper or electronic tracking sheet or system showing referral tracking and follow-up of multiple patients (blinded).

Factor 3: If the practice does not receive a report from the specialist, it contacts the specialist's office about the report's status and the expected date for receiving the report, and documents the effort to retrieve the report in a log or electronic system.

Factor 4: For patients who are regularly treated by a specific specialist, the primary care clinician and the specialist enter into an agreement that enables co management of the patient's care and includes timely sharing of changes in patient status and treatment plan. For co-managed patients, the primary clinician gives information to the specialist and receives information from the specialist within a period agreed to by both parties. This information is documented in the medical record.

Factor 5: Patients might see specialists without a referral from the medical home and without the medical home or clinician's knowledge. Clinicians should routinely ask patients if they have seen a specialist or are receiving care from a specialist and, if so, request a report from the specialist. The information should be documented in the medical record.

Factor 6: The practice is asked to show that its EHR technology has the capacity to electronically exchange key clinical information with facilities. That is, the practice needs to show its **capability** to send and receive key clinical information electronically (e.g., problem lists, medication lists, medication allergies, diagnostic test results) with other providers of care, with patient-authorized entities (such as health plans, an entity facilitating health information exchange among providers or a personal health record vendor identified by the patient. The key clinical information is based on the judgment of the clinician. There is no requirement for the practice to be able to exchange data on a regular basis now.

Factor 7: The practice provides an electronic summary-of-care record for more than 50 percent of referrals to the referred specialist(s). If the practice does not refer patients to other providers, they may respond NA to this factor. The practice must provide a written explanation of the NA response.

CMS provides the following additional information: "The referring party must provide the summary of care record to the receiving party. The clinician can send an electronic or paper copy of the summary of care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably be expected to do so. If the provider to whom the referral is made has access to the medical record maintained by the referring provider, the summary of care record would not need to be provided and that patient should not be included in the denominator for transitions of care."

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

The practice provides:
Factors 1–3: Reports or logs demonstrating data collected in the tracking system used by the practice. A paper log or a report from the electronic system meets the requirement; screen shots of a patient record do not meet the requirement. The report may be system generated or may be based on at least one week of referrals, with de-identified patient data.

Factors 4–5: The practice has a documented process, evidenced by at least three examples.

Factor 6: Screenshot or other documentation showing a test of the capability of the EHR to exchange key clinical information To qualify for Meaningful Use, the practice must meet the related factors using a certified HER

Factor 7: This element calls for calculation of a percentage that requires a numerator and a denominator. The practice provides reports from the electronic system. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation. The practice may use the following methodology to calculate the percentage.

- *Denominator* = Number of referrals during the EHR reporting period
- *Numerator* = Number of referrals in the denominator where a summary of care record was provided.

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Element 5C: Coordinate With Facilities and Manage Care Transitions

On its own or in conjunction with an external organization, the practice systematically:

	Yes	In Progress	No	NA
1.Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit	☐	☐	☐	
2. Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments	☐	☐	☐	
3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities	☐	☐	☐	
4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit	☐	☐	☐	
5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization	☐	☐	☐	
6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult only or family medicine practices)	☐	☐	☐	☐
7. Demonstrates the capability for electronic exchange of key clinical information with facilities	☐	☐	☐	
8.Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care	☐	☐	☐	☐

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When a "yes" response is entered in any item above, the following will appear:

If this PCMH element item only pertains to adult patients, please check here. (H) ○ Yes

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factor 1: The practice works with local hospitals, ERs and health plans to identify patients who were hospitalized and patients who had ER visits.

Factor 2: The practice provides facilities with appropriate and timely information about the patient.

Factor 3: The practice or external organization has a process for obtaining patient discharge summaries from hospitals, ERs, skilled nursing facilities, surgical centers and other facilities.

Factor 4: The practice contacts patients to evaluate their status after discharge from an ER or hospital and to make a follow-up appointment, if appropriate. Proactive contact includes offering patients appropriate care to prevent worsening of their condition and encouraging follow-up care. In addition to scheduling an appointment, follow-up care includes, but is not limited to, physician counseling; referrals to community resources; and disease or case management or self-management support programs. The practice's policies define the appropriate contact period.

Factor 5: The practice develops a two-way communication plan with hospitals to exchange information about hospitalized patients, enabling well-coordinated care during and after hospitalization.

Factor 6: During the transition from pediatric to adult care, it is important to promote health, disease prevention and psychosocial adjustment to adulthood. The practice's written care plan focuses on obtaining adult primary, emergency and specialty care and can include a summary of medical information (e.g., history of hospitalizations, procedures, tests), a list of providers, medical equipment and medications for patients with special health care needs, identified obstacles to transitioning to an adult care clinician and arrangements for release and transfer of medical records to the adult care clinician. Adult-only practices or family practices that do not transition pediatric patients to another clinician may enter an NA response. The practice must provide a written explanation for an NA response.

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Factor 7: The practice is asked to show that its EHR technology has the capacity to electronically exchange key clinical information with facilities. That is, the practice needs to show its **capability** to send and receive key clinical information electronically (e.g., problem lists, medication lists, medication allergies, diagnostic test results) with facilities (e.g., hospitals, ERs, extended care facilities, nursing homes other providers of care, The key clinical information is based on the judgment of the clinician. There is no requirement for the practice to be able to exchange data on a regular basis now. To qualify for Meaningful Use, the practice must meet the related factors using a certified EHR.

Factor 8: The practice that transitions patients to another care setting provides a summary of care record to other care settings (e.g., long-term care facilities, hospitals) for more than 50 percent of transitions of care. If the practice does not transfer patients to another setting they may respond NA to this factor. The practice must provide a written explanation of the NA response.

CMS provides the following additional information: "The transferring party must provide the summary of care record to the receiving party. If the provider to whom the referral is made or to whom the patient is transitioned has access to the medical record maintained by the referring provider, the summary of care record would not need to be provided and that patient should not be included in the denominator for transitions of care."

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

The practice provides:

Factor 1: A documented process showing that it identifies patients who have been hospitalized or have had an ER visit; a log of patients receiving care from different types of facilities; or a report listing patients seen in the ER or hospital.

Factor 2: A documented process of how it provides hospitals and ERs with clinical information; at least three de-identified examples of patient information sent to the hospital or ER.

Factor 3: A documented process for obtaining hospital discharge summaries and at least three examples of a discharge summary.

Factor 4: A documented process that includes the practice's period for patient follow-up after a hospital admission or ER visit; at least three de-identified examples of documented patient follow-up in the medical record, or a log with at least one week of data documenting systematic follow-up.

Factor 5: A documented process for two-way communication with hospitals and an example of two-way communication.

Factor 6: A copy of a written transition care plan.

Factor 7: Screenshot or other documentation showing a test of the capability of the EHR to exchange key clinical information

> To qualify for Meaningful Use, the practice must meet the related factors using a certified HER

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Factor 8: This element calls for calculation of a percentage that requires a numerator and a denominator. The practice provides reports from the electronic system. The practice may use the following methodology to calculate the percentage based on 12 months of data in the electronic system. If the practice does not have 12 months of data, it may use a recent 3-month period for the calculation.

The practice may use the following methodology to calculate the percentage.

- *Denominator* = Number of transitions to another care setting during the EHR reporting period
- *Numerator* = Number of transitions of care in the denominator where a summary of care record was provided.

PCMH 6: Measure and Improve Performance

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

Element 6A: Measure Performance

The practice measures or receives data on the following

	Yes	In Progress	No
1. At least three preventive care measures	☐	☐	☐
2. At least three chronic or acute care clinical measures	☐	☐	☐
3. At least two utilization measures affecting health care costs	☐	☐	☐
4. Performance data stratified for vulnerable populations (to assess disparities in care).	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

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Explanation

The practice reviews its performance on a range of measures to help it understand its care delivery system's strengths and opportunities for improvement. Data may be from internal or external sources. If an external source (such as a health plan) provides the data, the practice must state that the information represents 75 percent of its eligible population. While some measures may fit into multiple categories appropriately, each measure may be used only once for this element.

When it selects measures of performance, the practice must document the period of measurement, the number of patients represented by the data and the patient selection process.

Factor 1: Preventive measures include: 1) services recommended by the U.S. Preventive Services Task Force (USPSTF), 2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), 3) preventive care and screenings for children and for women as recommended by the Health Resources and Services Administration (HRSA) or 4) other standardized preventive measures, including those identified in *Bright Futures* for pediatric patients. Examples of measures include:

- Cancer screening

- Developmental screening
- Immunizations
- Osteoporosis screening
- Depression screening
- Assessment of behaviors affecting health, such as smoking, BMI and alcohol use.

The CMS definition of preventive services is "routine health care that includes screenings, checkups and patient counseling to prevent illnesses, diseases or other health problems." http://www.healthcare.gov/law/about/provisions/services/lists.html

Factor 2: Chronic or acute care clinical measures may be associated with the three important conditions or others tracked by the practice (e.g., diabetes, heart disease, asthma, depression, chronic back pain, otitis media), based on evidence-based guidelines. Measures of overuse of potentially ineffective interventions, such as overuse of antibiotics for bronchitis, may also be used.

Practices where 75 percent or more of the clinicians have earned recognition in the NCQA PCMH 2011 Heart/Stroke Recognition Program (HSRP), Diabetes Recognition Program (DRP) or Back Pain Recognition Program (BPRP) automatically receive credit for factor 2 for recognitions that are current when the practice submits its PCMH Survey Tool. The practice should include a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice.

Factor 3: The practice uses resources judiciously to help patients receive appropriate care. The types of measures monitored for this factor are intended to help practices understand how efficiently they provide care, and may include ER visits, potentially avoidable hospitalizations and hospital readmissions, redundant imaging or lab tests, prescribing generic medications vs. brand name medications and number of specialist referrals. Practices may use data from one or more payers that cover at least 75 percent
of patients, or may collect data over time.

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Factor 4: The data collected by the practice for one or more measures from factors 1–3 is stratified by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics, such as age, gender, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status.

Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–4: The practice provides reports showing performance on the required measures.

Element 6B: Measure Patient/Family Experience

The practice obtains feedback from patients/families on their experiences with the practice and their care.

	Yes	In Progress	No	NA
1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: **• Access** **• Communication** **• Coordination** **• Whole-person care/self-management support**	☐	☐	☐	
2. The practice uses the CAHPS Patient-Centered Medical Home (PCMH) 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	☐	☐	☐	

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice may use a telephone, paper or electronic survey, and uses survey feedback to inform its quality improvement activities. The patient survey must represent the practice population including all relevant subpopulations and may not be limited to patients of only one of several clinicians or data from one payer when there are multiple payers.

Factor 1: The practice or practice designee surveys patients to assess patient/family experience. The survey must include questions related to at least three of the following categories:

- Access may include routine, urgent and after-hours care
- Communication with the practice, clinicians and staff may include feeling respected, listened to and able to get answers to questions
- Coordination of care may include being informed and up-to-date on referrals to specialists, changes in medications and lab or imaging results

• Whole person care/self-management support may include the provision of comprehensive care and self-management support and emphasizing the spectrum of care needs such as mental health; routine and urgent care; advice, assistance and support for making changes in health habits and making health care decisions.

Factor 2: The practice uses the standardized CAHPS Patient-Centered Medical Home (PCMH) survey tool to collect patient experience data.

Note

• *The CAHPS Patient-Centered Medical Home (PCMH) Survey Tool was released September 30, 2011.*
At that time, practices may use it to collect patient experience data to meet Factor 2. Since it was not available until early fall, 2011, Factor 2 may be marked NA until April 1, 2012. As of April 1, 2012, the
NA option will no longer be available.
• *In addition, in April 2012, practices will be able to receive Distinction from NCQA PCMH 2011 for using the CAHPS*
PCMH survey to collect patient experience data and:
- *Using a specific methodology for collecting the data,*
- *Using a certified vendor to collect the data and*
- *Reporting the results to NCQA PCMH 2011 which will be used to benchmark patient experience data.*

Factor 3: The practice uses survey data or other means to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may provide the basis for the sub-groups. Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

Factor 4: Qualitative feedback methods may include focus groups, individual interviews, patient walkthrough and suggestion boxes. Practices may use a feedback methodology conducive to its population of patients/families or parents, such as "virtual" participation such as by phone or video conference.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–4: The practice provides reports with summarized results of patient feedback. A blank Survey Tool does not meet the intent of this element.

Element 6C: Implement Continuous Quality Improvement

The practice uses an ongoing quality improvement process to:

	Yes	In Progress	No
1. Set goals and act to improve performance on at least three measures from Element A	☐	☐	☐
2. Set goals and act to improve performance on at least one measure from Element B	☐	☐	☐
3. Set goals and address at least one identified disparity in care or service for vulnerable populations	☐	☐	☐
4. Involve patients/families in quality improvement teams or on the practice's advisory council.	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice must have a clear and ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer the practice an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

The practice sets goals and establishes a plan to improve performance on clinical quality and resource measures (Element A) and patient experience measures (Element B).

The practice **may** participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.

Resource: One resource for the PDSA cycle is the Institute for Healthcare Improvement (IHI): http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/.

Factors 1 and 2: The practice sets goals and acts to improve performance, based on clinical and resource measures (Elements A) and patient experience measures (Element B). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

Factor 3: The practice identifies areas of disparity among vulnerable populations, sets goals and acts to improve performance in these areas. Vulnerable groups should reflect the practice's population

demographics, such as age, gender, race, ethnicity, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status.

Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co morbid conditions or who are at high risk for frequent hospitalization or ER visits

Factor 4: The practice has a process for involving patients and their families in its quality improvement efforts. At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team meetings.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1–3: The practice provides reports or a completed PCMH Quality Measurement and Improvement Worksheet.

Factor 4: The practice provides a process and examples of how it meets the process (e.g., meeting notes, agenda).

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Element 6D: Demonstrate Continuous Quality Improvement

The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:

	Yes	In Progress	No
1. Tracking results over time	☐	☐	☐
2. Assessing the effect of its actions	☐	☐	☐
3. Achieving improved performance on one measure	☐	☐	☐
4. Achieving improved performance on a second measure	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation Quality improvement is a continual process that is built into the practice's daily operations and requires an ongoing effort of assessing, improving and reassessing. This element emphasizes ongoing quality improvement, by comparing performance results to demonstrate that the practice has gone beyond setting goals and taking action.

Resource: Solberg, L.I., G. Mosser, S. McDonald. 1997. The Three Faces of Performance Measurement: Improvement, Accountability and Research. *Journal on Quality Improvement.* 23(3); 135-47.

Factor 1: The practice demonstrates that it collects clinical, resource (Element A) or patient experience (Element B) performance data and assesses the results over time. The number and frequency of the comparative data collection points (e.g., monthly, quarterly, biannually, yearly) are established by the practice.

Factor 2: In Element C, the practice sets goals and acts to improve performance on clinical quality and resource measures (Element A) and on patient experience measures (Element B). In factor D, the practice identifies the steps it has taken and evaluates these steps to improve performance. The practice is not required to demonstrate improvement in this factor.

Factors 3 and 4: The practice must demonstrate that its performance on the measures has improved over time, based on its assessment.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: The practice provides reports, recognition results or a completed PCMH Quality Measurement and Improvement Worksheet showing performance measures over time.

Factor 2: The practice provides reports or a completed PCMH Quality Measurement and Improvement Worksheet on improvement activities and the results.

Factors 3 and 4: The practice provides reports, recognition results or a completed PCMH Quality Measurement and Improvement Worksheet showing improvement on performance measures.

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Element 6E: Report Performance

The practice shares performance data from Element A and Element B:

	Yes	In Progress	No
1. Within the practice, results by individual clinician	☐	☐	☐
2. Within the practice, results across the practice	☐	☐	☐
3. Outside the practice to patients or publicly, results across the practice or by clinician.	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice may use data that it produces or may use data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan. Performance results must reflect care provided to all patients the practice cares for (relevant to the measure), not only patients covered by a specific payer. Data are:

- Reported to individual clinicians and practice staff (e.g., via memos, staff meeting agendas, minutes)
- Reported publicly by the health plan
- Made available to patients.

Factor 1: The practice provides individual clinician reports to clinicians and practice staff. Reports reflect the care provided by the care team.

Factor 2: The practice provides practice-level reports to clinicians and practice staff.

Factor 3: Data are reported or made available to practice staff and patients or made public by a health plan or other entity. Reporting to patients may include posting in the practice's waiting room, through a letter or e-mail, on the practice's Web site or through a mass mailing to patients.

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1 and 2: The practice provides blinded reports to the practice or to clinicians and practice staff, showing summary practice or individual clinician performance, **and** explains how it provides results.

Factor 3: The practice provides an example of its reporting to patients or to the public.

Element 6F: Report Data Externally

The practice electronically reports:

	Yes	In Progress	No	NA
1. Ambulatory clinical quality measures to CMS or states	☐	☐	☐	
2. Ambulatory clinical quality measures to other external entities	☐	☐	☐	
3. Data to immunization registries or systems	☐	☐	☐	☐
4. Syndromic surveillance data to public health agencies	☐	☐	☐	☐

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

Factor 1: The practice reports ambulatory clinical quality measures required for Meaningful Use following CMS specifications to CMS or states. Reporting by attestation is required in 2011; electronic reporting is required in 2012.

For requirements and electronic specifications related to individual ambulatory clinical quality measures, refer to:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopofPage

Factor 2: The practice reports ambulatory clinical quality measures to entities other than reporting to CMS or the states for meaningful use such as the Health Resources and Services Administration (HRSA) uniform data set (UDS). To qualify the performance data must be transmitted electronically from the practice's source data system (e.g. EHR), NOT manually extracted.

Factor 3: The practice performed at least one test of the EHR technology's capacity to submit electronic data to immunization registries or immunization information systems and follow up submission if the test is successful. This factor will be NA if none of the immunization registries to which the practice submits such information has the capacity to receive the information electronically or if the practice administered no immunizations during the past 12 months (3 months if 12 months of data is not available).

Factor 4: The practice performed at least one test of the EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful. This factor will be NA if none of the public health agencies to which the practice submits such information has the capacity to receive the information electronically or if the practice did not collect any reportable syndromic information on their patients during the past 12 months (3 months if 12 months is not available).

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factors 1 and 2: The practice provides *reports* demonstrating electronic data transmission to CMS, states, other entities and public health agencies.

Factors 3 and 4: The practice provides *reports* demonstrating electronic data submittal to immunization registries and public health agencies or a *screen shot* demonstrating that the capability was tested.

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Element 6G: Use Certified EHR Technology

This element is for your practice site Meaningful Use report only and will *NOT* be scored for your PCMH Recognition decision.

NOTE: Factor 1 requires comments

	Yes	In Progress	No	Comment Needed
1. The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List (CHPL) Number(s) under the ONC (Office of the National Coordinator for Health Information Technology) HIT certification program	☐	☐	☐	
2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules) and implementing security updates as necessary and correcting identified security deficiencies	☐	☐	☐	NA

When a "yes" response is entered in any item above, the following will appear:

- If this item only pertains only to adult patients in your practice, please click "yes".
- If this item also pertains to pediatric and/or adolescent patients in your practice, please leave this blank and continue on to the next item.

Explanation

The practice protects the privacy and security of the electronic health information within its certified electronic health record (EHR) system (or modules.)

CMS states that the objective is to "protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities." "All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology."

The following links provide additional information:

- U.S. Department of Health & Human Services, Health Information Privacy Web site link: http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html
- Link for Core Meaningful Use requirement #15, Protect Electronic Health

Information:http://www.cms.gov/EHRIncentivePrograms/Downloads/15ProtectElectronicHealthInformation.pdf

Factor 1: The practice provides the Certified HIT Products List (CHPL) Number(s) number(s) of the software system (or modules) used by the practice. Since the practice may use more than one software system, **all** must be listed.

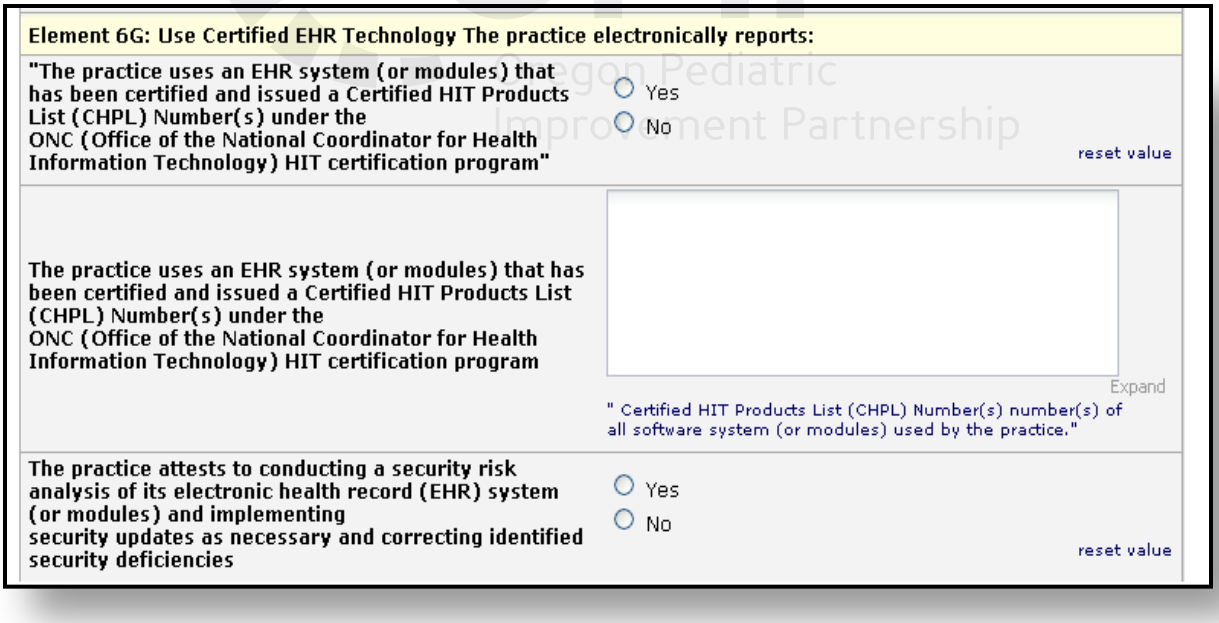
Factor 2: The practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies. CMS requires eligible professionals to "conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security analysis updates as necessary and correct identified security deficiencies prior to or during the EHR reporting period."

DOCUMENTATION REQUIRED FOR PRACTICES SEEKING NCQA PCMH 2011 RECOGNITION

Factor 1: In the comment box in the survey tool, the practice enters the Certified HIT Products List (CHPL) Number(s) of **all** EHR systems (or modules) the practice uses to perform the designated Core and Menu Meaningful Use requirements.

Factor 2: By entering a "yes" response in the PCMH 2011 survey tool, the practice **attests** to: conducting the required security risk analysis of its certified EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies

Below is an example of how the NCQA PCMH 2011 will appear in REDCap:



MODULE 5: ADDITIONAL ITEMS – OREGON

INSTRUCTIONS

The following items were identified to gain a better understanding of practices in Oregon that are and are not participating in the T-CHIC quality efforts. Please read each item and select the answer that best describes your practice. Text boxes have been provided for responses that require additional information.

Appendix B contains the **Glossary** for key terms that are used in the items. Additionally, in the REDCap tool there are instructions that can be accessed. If you have specific questions about the terms/items in this tool please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

Note: In REDCap, when possible, survey item information will be been entered for you. This is noted in green below. Please review these items and correct any erroneous entries.

1. Study ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -**A unique, assigned ID that allows for de-identification of practice Information)

2. Group ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A de-identified, assigned indicator to allow the grouping of analyses by state.)
   AK = O
   OR = C
   WV = H

3. Date of Completion

   _____/_____/_____
   (mm / dd / yyyy)

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4. Are you involved in any of the following quality efforts (Check all that apply):
   - ☐ QUALIS Safety Net medical Home
   - ☐ Q-CORP, Aligning Forces for Quality Clinic Quality Measurement Initiative
   - ☐ David Dorr Med Home Effort
   - ☐ Other Medical Home Initiatives (Please specify below)
   - ☐ Others (Please specify below)

4a. Other Medical Home Initiatives – Please specify:_____

_____

_____

4b. Others – Please specify:_____

_____

_____

5. How familiar/knowledgeable are you about the concept of a medical home as defined by **Oregon Health Authority's Patient-Centered Primary Care Homes**? (http://www.primarycarehome.oregon.gov/)
   - ☐ No knowledge of the concepts
   - ☐ Some knowledge/not applied
   - ☐ Knowledgeable/concept sometimes applied in practice
   - ☐ Knowledgeable/concepts regularly applied in practice
   - ☐ N/A, instrument not used
   - ☐ Unknown

WARNING!! Please save the data that you have entered before you click on the Oregon Health Authority's Patient-Centered Primary Care Homes link. Otherwise, your data will be lost when you return to REDCap.

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6. Are you applying for the **Oregon Patient-Centered Primary Care Home recognition?** http://www.primarycarehome.oregon.gov/
   - ☐ Yes, we have already applied
   - ☐ Yes, we are submitting the PCPCH recognition application within the next 6 months
   - ☐ Yes, we are planning to submit the PCPCH recognition application in the future (> 6 months from now)
   - ☐ No, we are not currently planning to submit the PCPC recognition application
   - ☐ Not sure

WARNING!! Please save the data that you have entered before you click on the Oregon Patient-Centered Primary Care Home recognition link. Otherwise, your data will be lost when you return to REDCap.

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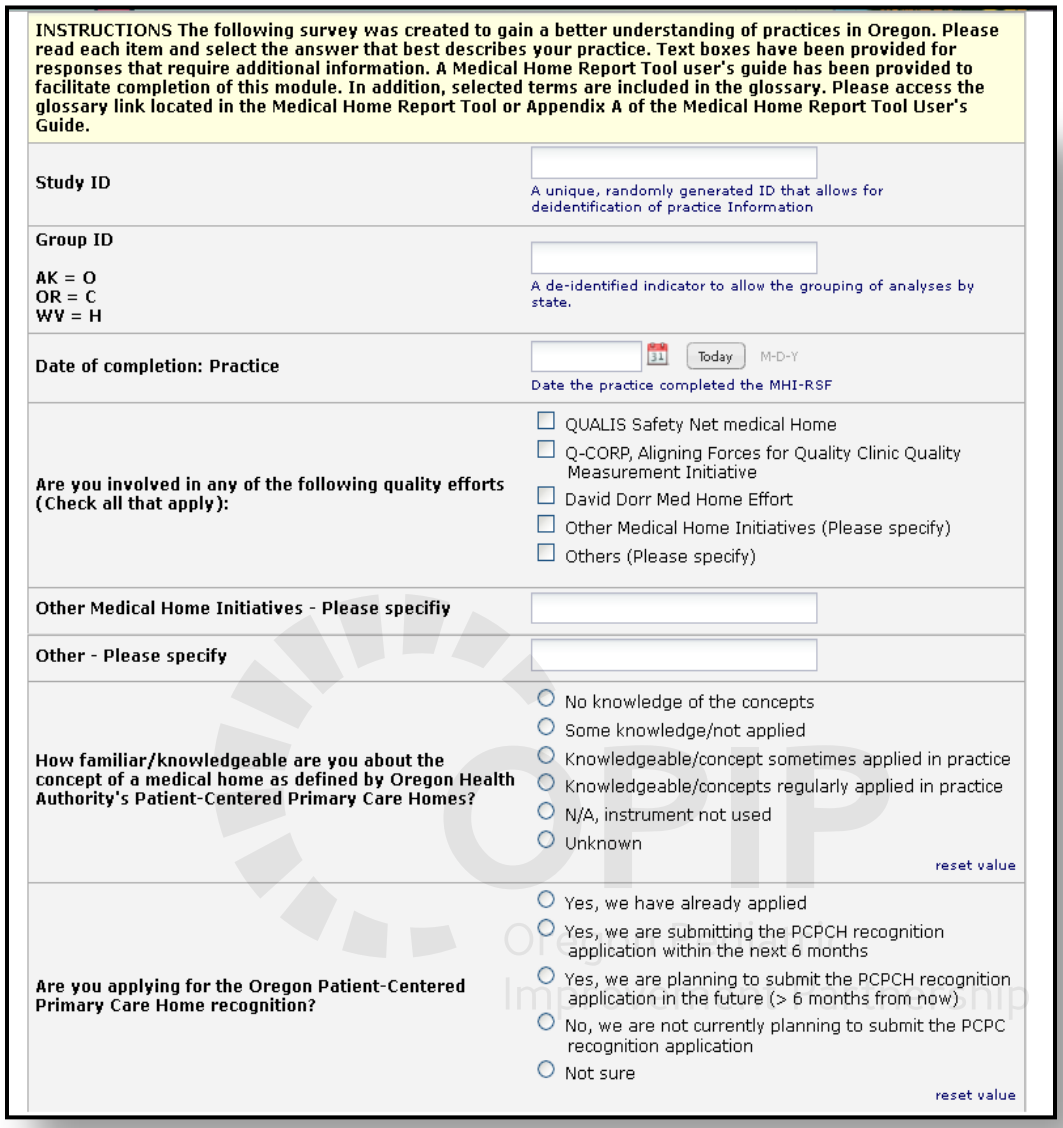
Below is how the Additional Items for Oregon will appear in REDCap:



INSTRUCTIONS The following survey was created to gain a better understanding of practices in Oregon. Please read each item and select the answer that best describes your practice. Text boxes have been provided for responses that require additional information. A Medical Home Report Tool user's guide has been provided to facilitate completion of this module. In addition, selected terms are included in the glossary. Please access the glossary link located in the Medical Home Report Tool or Appendix A of the Medical Home Report Tool User's Guide.

Study ID

A unique, randomly generated ID that allows for deidentification of practice Information

Group ID

AK = O
OR = C
WV = H

A de-identified indicator to allow the grouping of analyses by state.

Date of completion: Practice

Today M-D-Y

Date the practice completed the MHI-RSF

Are you involved in any of the following quality efforts (Check all that apply):

- ☐ QUALIS Safety Net medical Home
- ☐ Q-CORP, Aligning Forces for Quality Clinic Quality Measurement Initiative
- ☐ David Dorr Med Home Effort
- ☐ Other Medical Home Initiatives (Please specify)
- ☐ Others (Please specify)

Other Medical Home Initiatives - Please specifiy

Other - Please specify

How familiar/knowledgeable are you about the concept of a medical home as defined by Oregon Health Authority's Patient-Centered Primary Care Homes?

- ○ No knowledge of the concepts
- ○ Some knowledge/not applied
- ○ Knowledgeable/concept sometimes applied in practice
- ○ Knowledgeable/concepts regularly applied in practice
- ○ N/A, instrument not used
- ○ Unknown

reset value

Are you applying for the Oregon Patient-Centered Primary Care Home recognition?

- ○ Yes, we have already applied
- ○ Yes, we are submitting the PCPCH recognition application within the next 6 months
- ○ Yes, we are planning to submit the PCPCH recognition application in the future (> 6 months from now)
- ○ No, we are not currently planning to submit the PCPC recognition application
- ○ Not sure

reset value

MODULE 6: ADDITIONAL ITEMS – ALASKA

INSTRUCTIONS

The following survey was created to gain a better understanding of practices in Alaska. Please read each item and select the answer that best describes your practice. Text boxes have been provided for responses that require additional information.

Appendix B contains the **Glossary** for key terms that are used in the items. Additionally, in the REDCap tool there are instructions that can be accessed. If you have specific questions about the terms/items in this tool please contact Amber Laurie of the Oregon Pediatric Improvement Partnership (OPIP): **lauriea@ohsu.edu**.

Note: In REDCap, when possible, survey item information will be been entered for you. This is noted in green below. Please review these items and correct any erroneous entries.

1. Study ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A unique, assigned ID that allows for de-identification of practice Information)

2. Group ID

   _____

   (**USE THE ANSWER GRID SHEET PROVIDED BY OPIP TO FILL IN THE CORRECT ANSWER -** A de-identified, assigned indicator to allow the grouping of analyses by state.)

   AK = O

   OR = C

   WV = H

3. Date of Completion

   _____/_____/_____

   (mm / dd / yyyy)

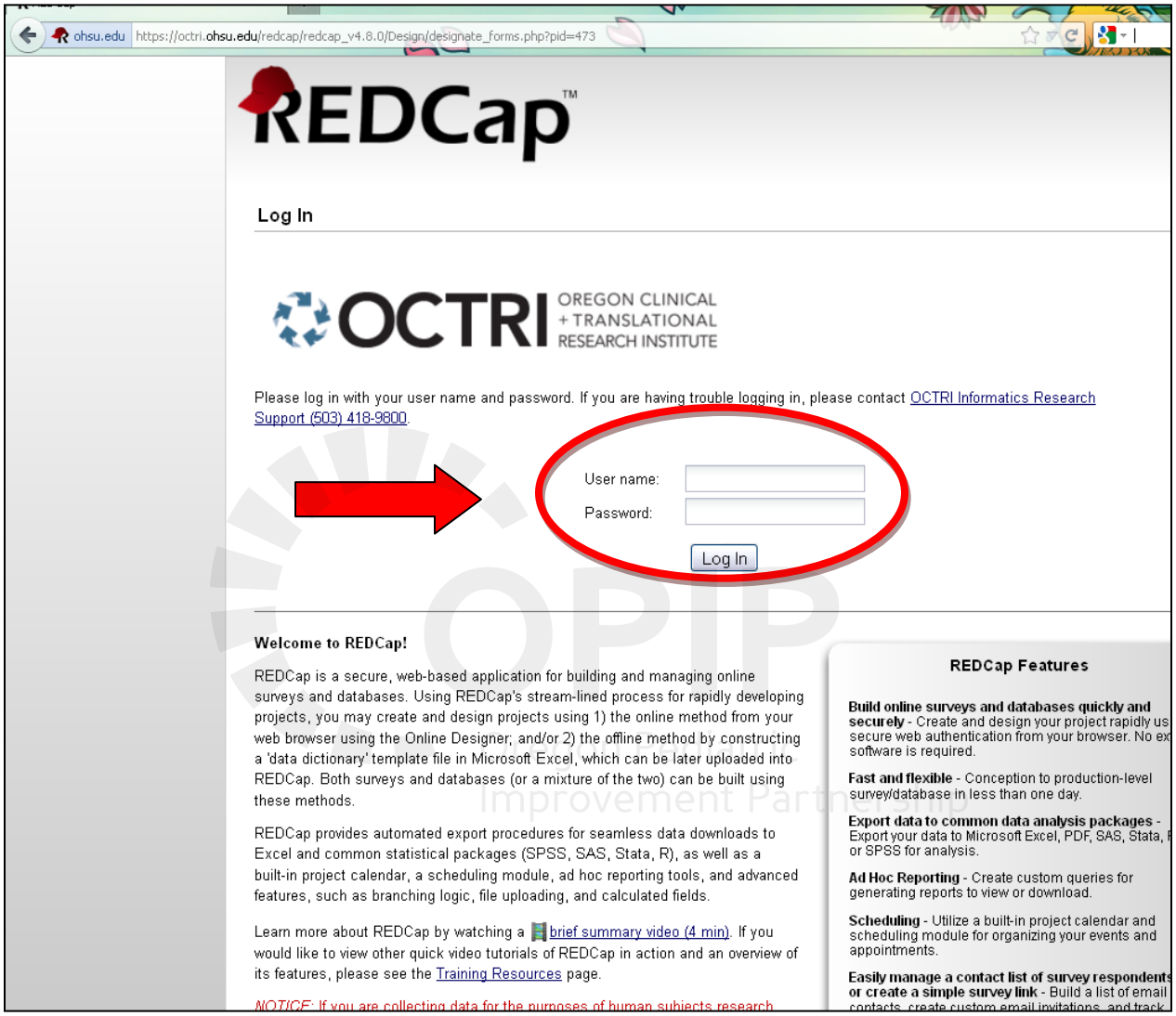
4. How familiar/knowledgeable are you about the concept of **a medical home as defined by Alaska Medicaid/CHIP program** and that was included in the **Request for Proposal in this project**?

   - ☐ No knowledge of the concepts
   - ☐ Some knowledge/not applied
   - ☐ Knowledgeable/concept sometimes applied in practice
   - ☐ Knowledgeable/concepts regularly applied in practice
   - ☐ N/A, instrument not used
   - ☐ Unknown

ENTERING DATA INTO REDCAP (Step 4 in Figure 1.0 on Page 5)

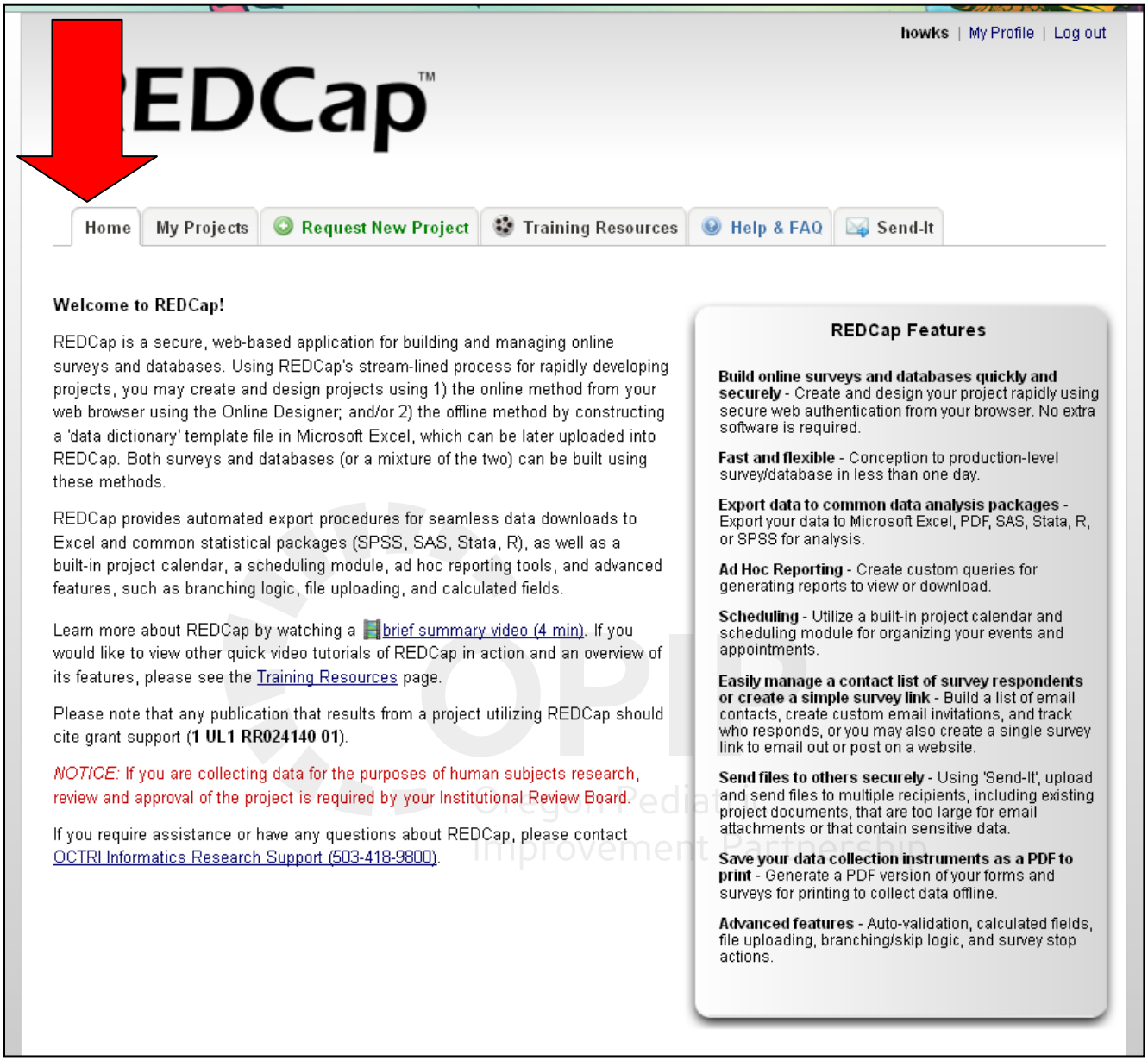
Accessing the Medical Home Measurement Tool

- REDCap can be accessed at the follwing website: https://octri.ohsu.edu/redcap/



Enter User name and Password – *This will be assigned to you*. Users will be assigned to a User Group and will only see the forms/data for that User Group.

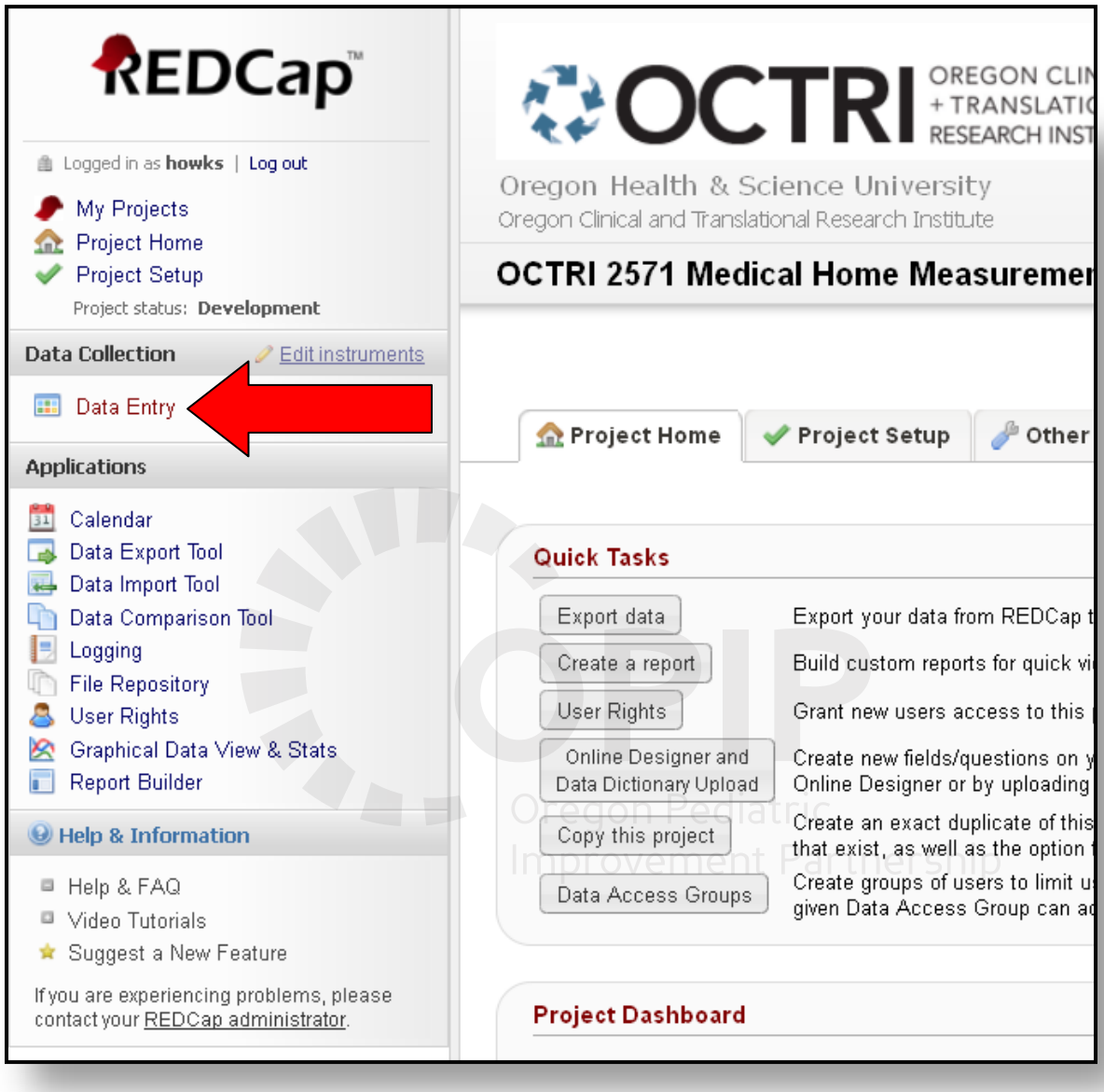
- Once you have logged-in, you will be on the “Home” tab.



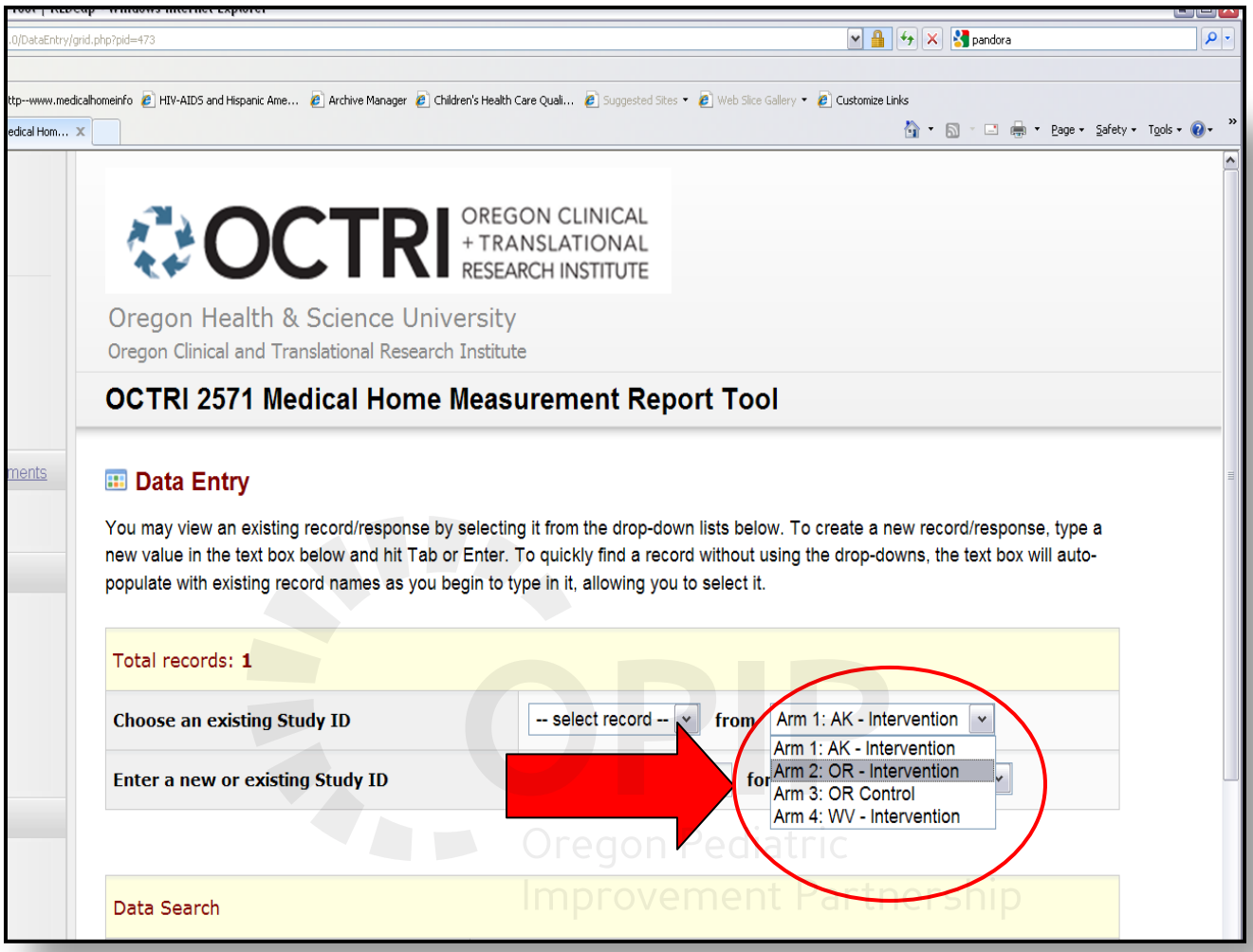
- Click on the “My Projects” tab. This is located next to the “Home” tab and will take you to a list of available databases.

- You will only have one database on your list; the OCTRI 2571 Medical Home Measurement Report Tool.

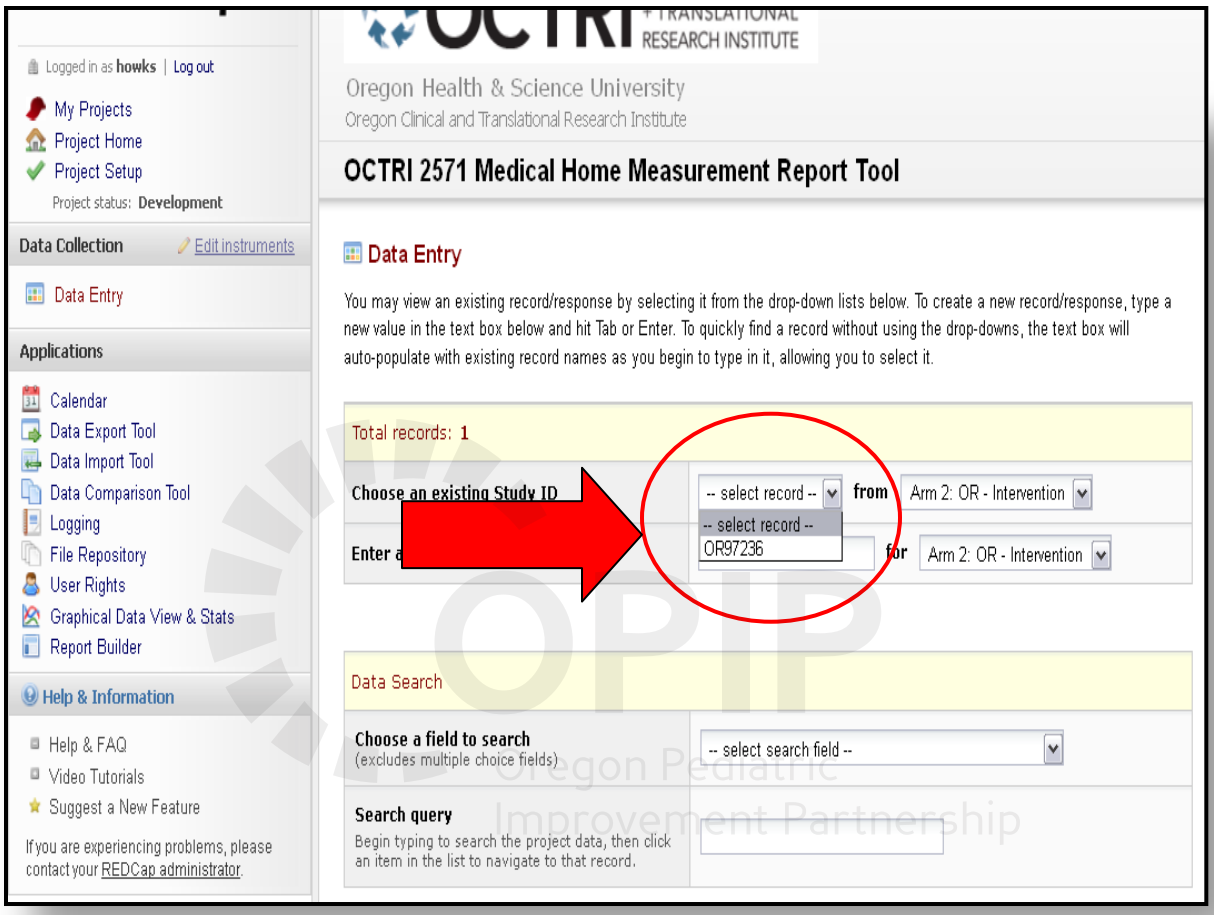
- Once in the database, find and click on the “Data Entry” link in the menu on the left side of the screen.



- For persons entering data for multiple practices (Jean Fisher in WV, ECHO Percs), choose the state and group (*intervention or control, only applicable for Oregon Sites*).

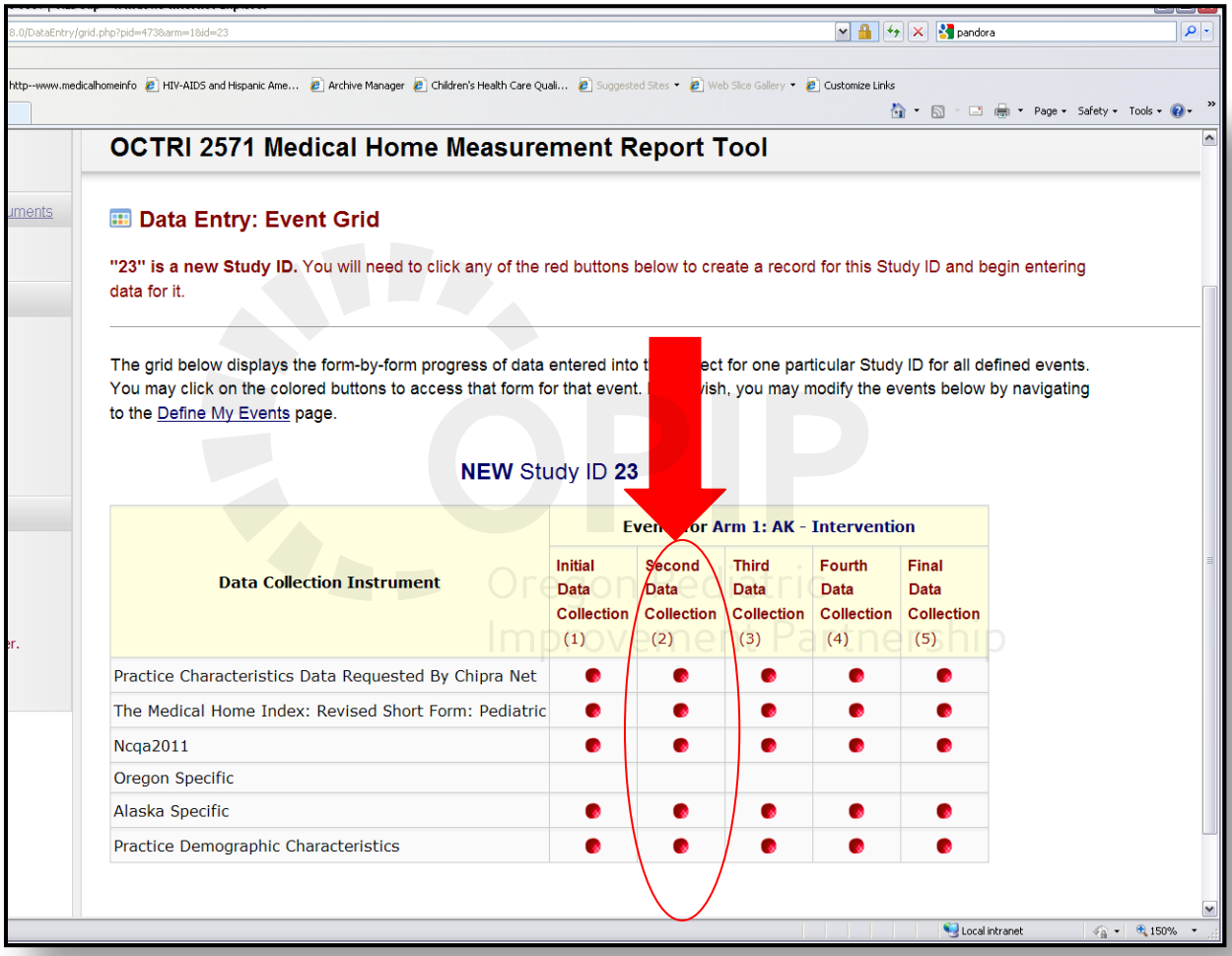


- For Oregon and West Virginia:
    - Locate the Study ID of the clinic for which you are entering data.
- For Alaska and Oregon Non-ECHO sites:
    - For individuals who are only entering data for ONLY your practice (Alaska sites), only the STUDY ID, state and Group ID that have been assigned to you will be visible.

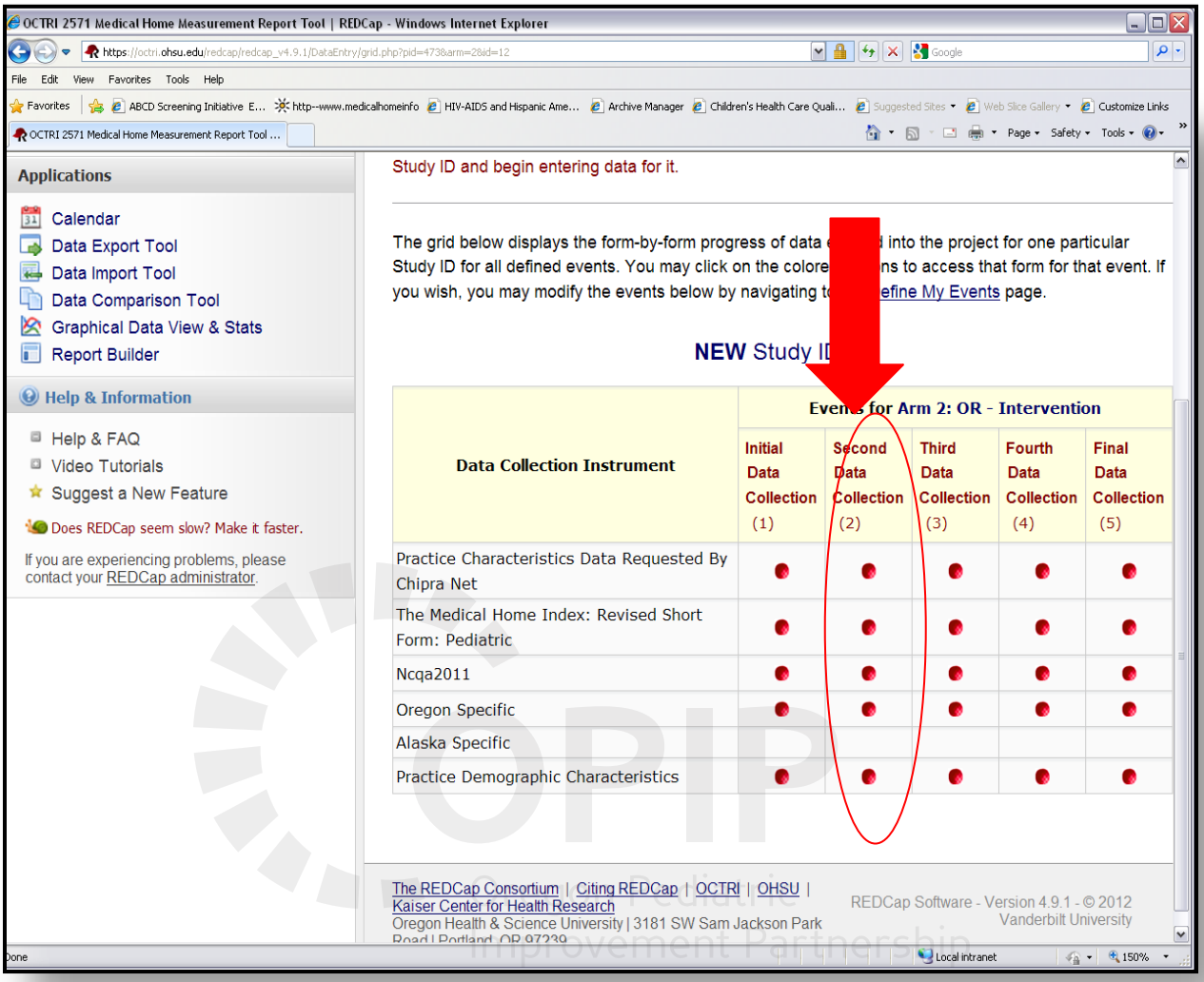


- This will take you to the Event Grid.
- Choose the Second Data Collection form from the Event Grid.
- **Please make check to ensure that you are selecting the correct module for which you are entering information (E.g. Practice Demographic Characteristics).**
    - **Again, for this second round of data collection** it is important to answer the Medical Home Office Report Measurement Tool about your practice **after initiation of quality improvement activities for the T-CHIC Medical Home Improvement Activities**.

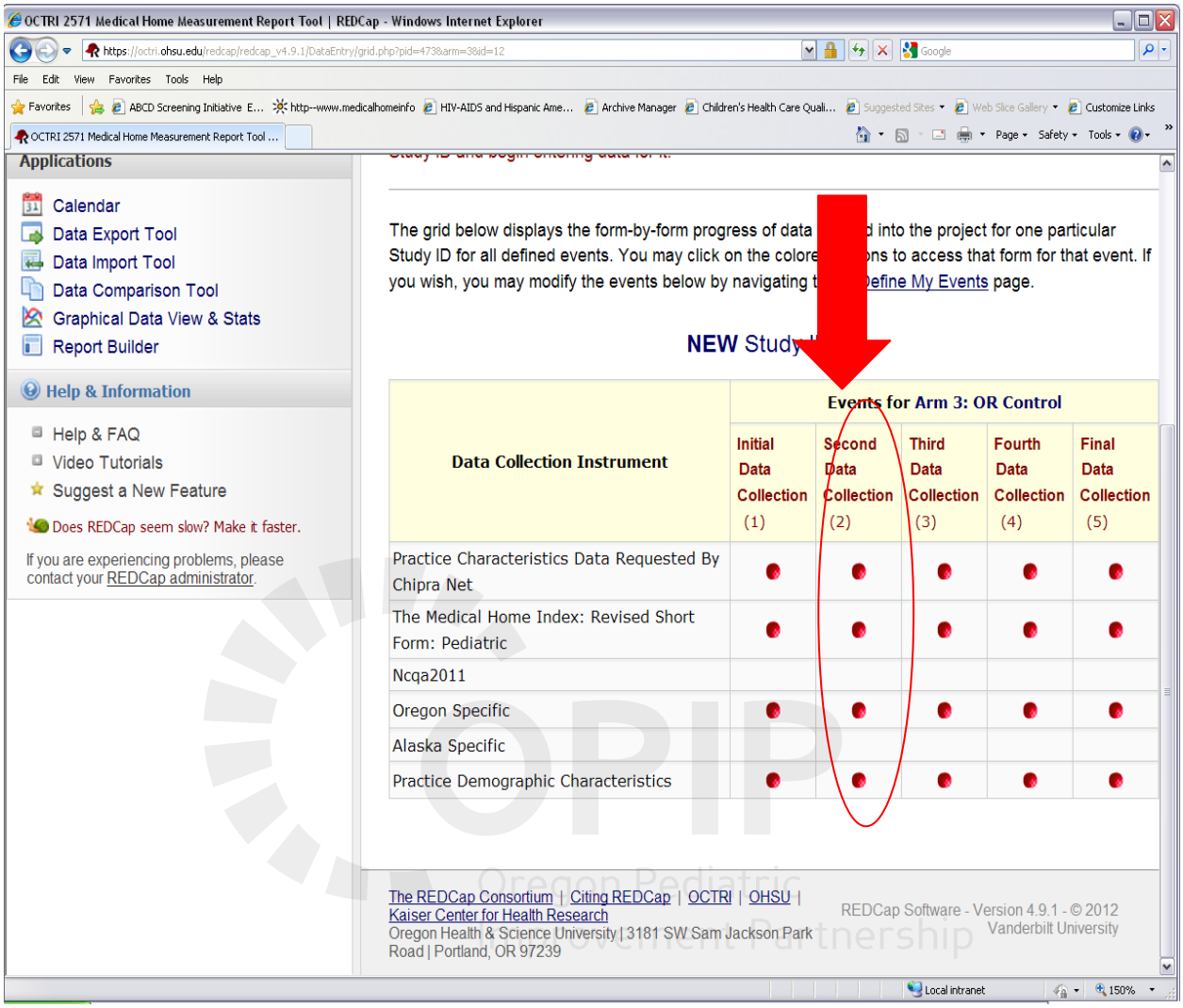
Alaska View:



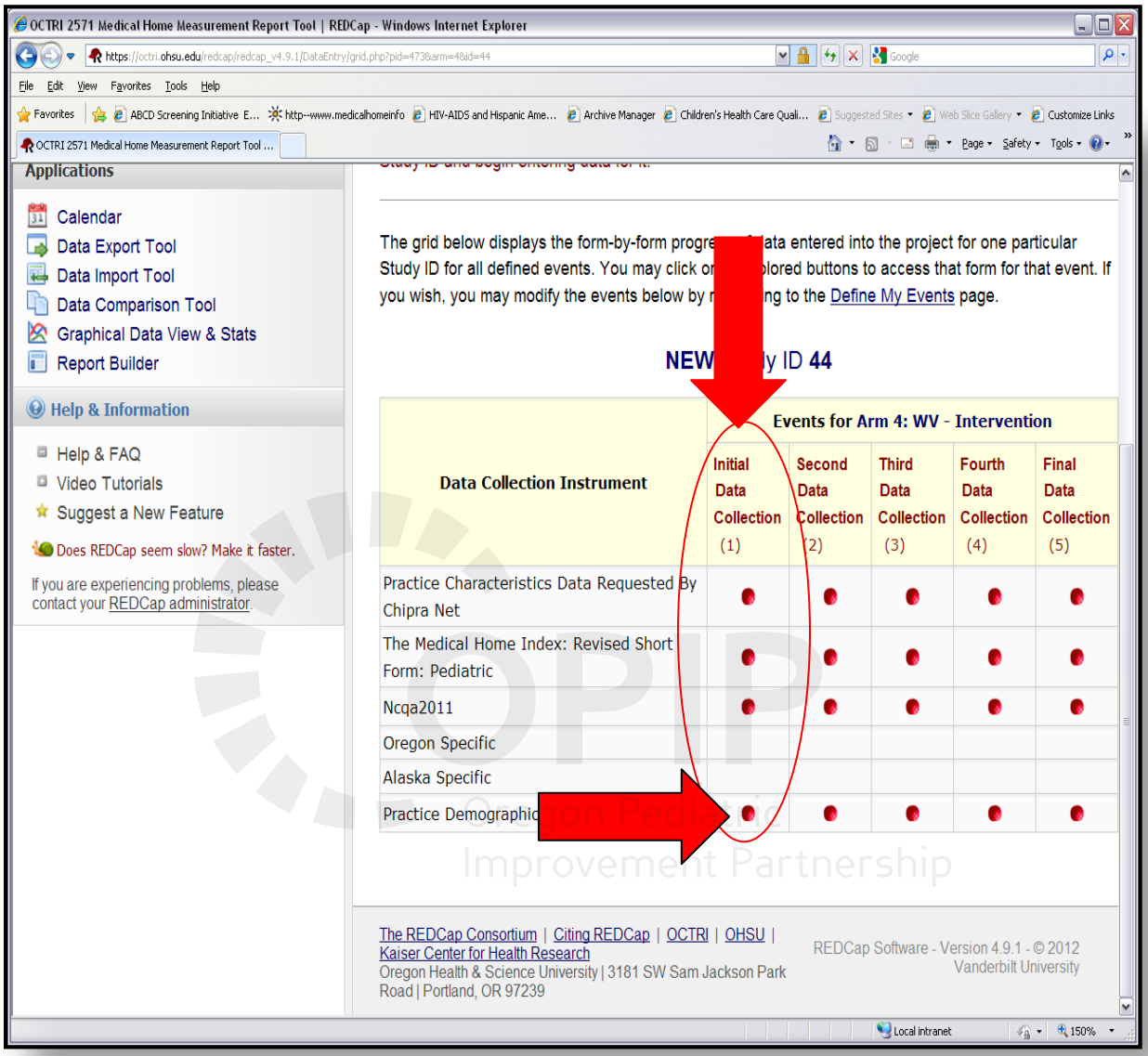
Oregon Intervention Site View:



Oregon Comparison Site View

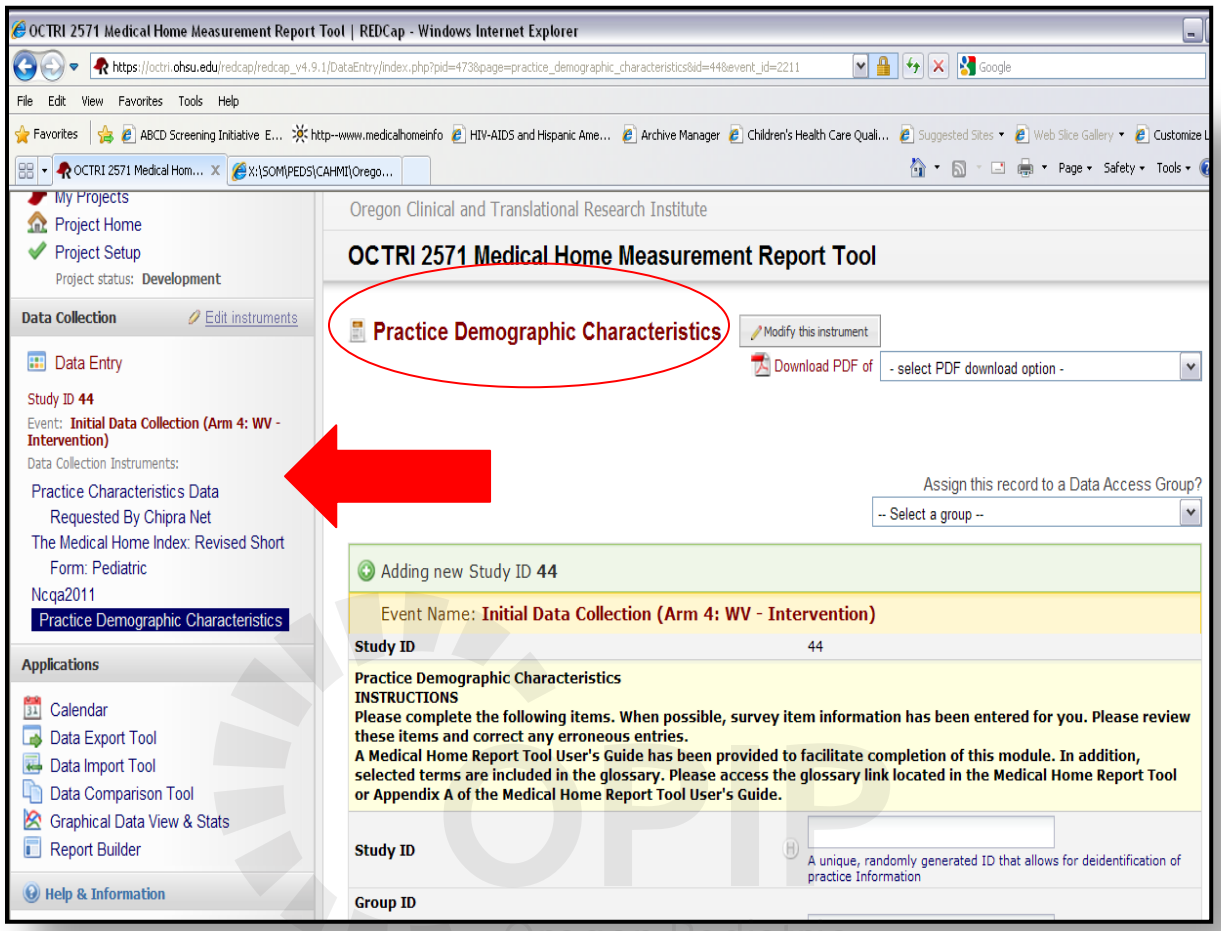


WV Intervention Site View



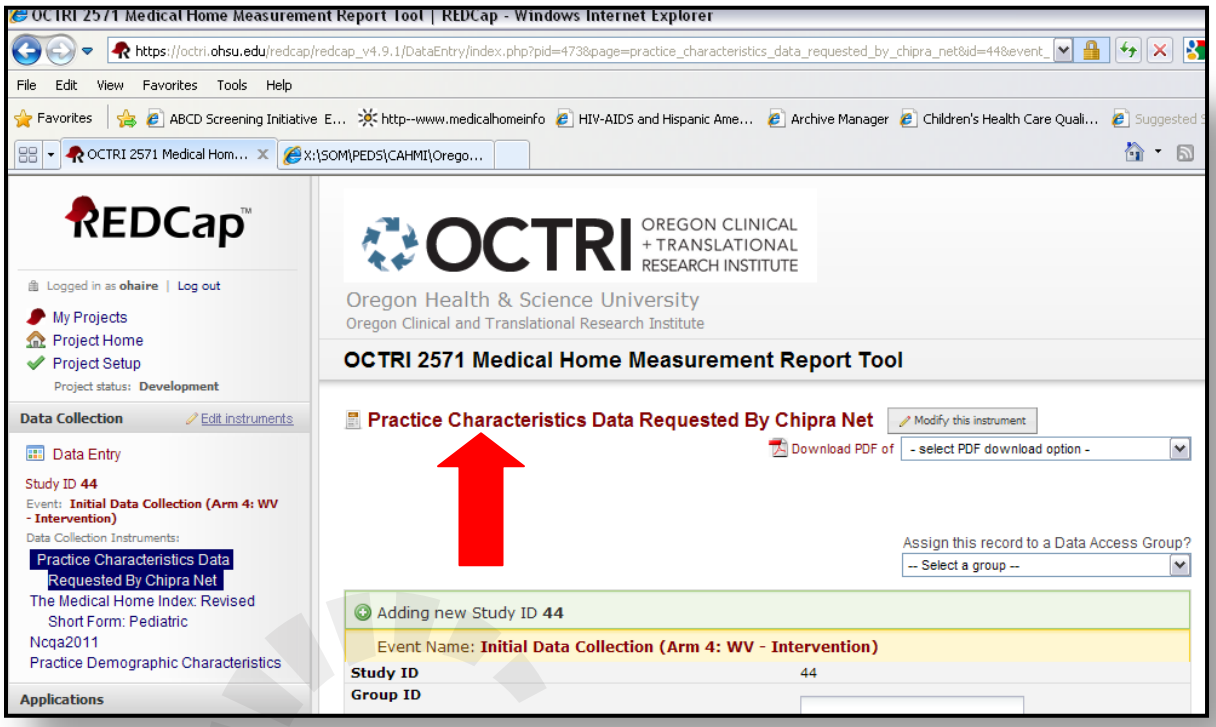
- Regardless of your site, click on the radio button for the Medical Home Office Report Measurement ToolModule that you are entering practice data.

DEMOGRAPHIC FORM

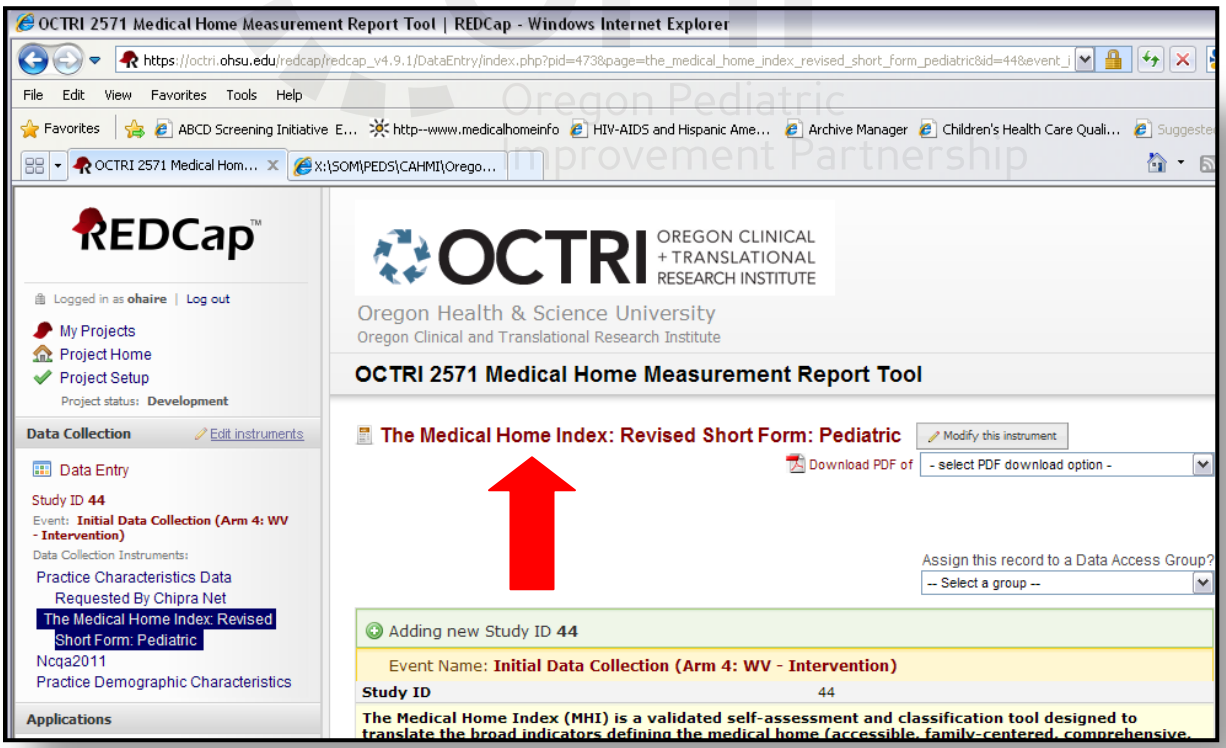


- The Practice Demographic Characteristics page looks like this. On the left side near the arrow, you can select other modules by clicking on them. Note: Don't forget to save (see below) before you toggle between modules.

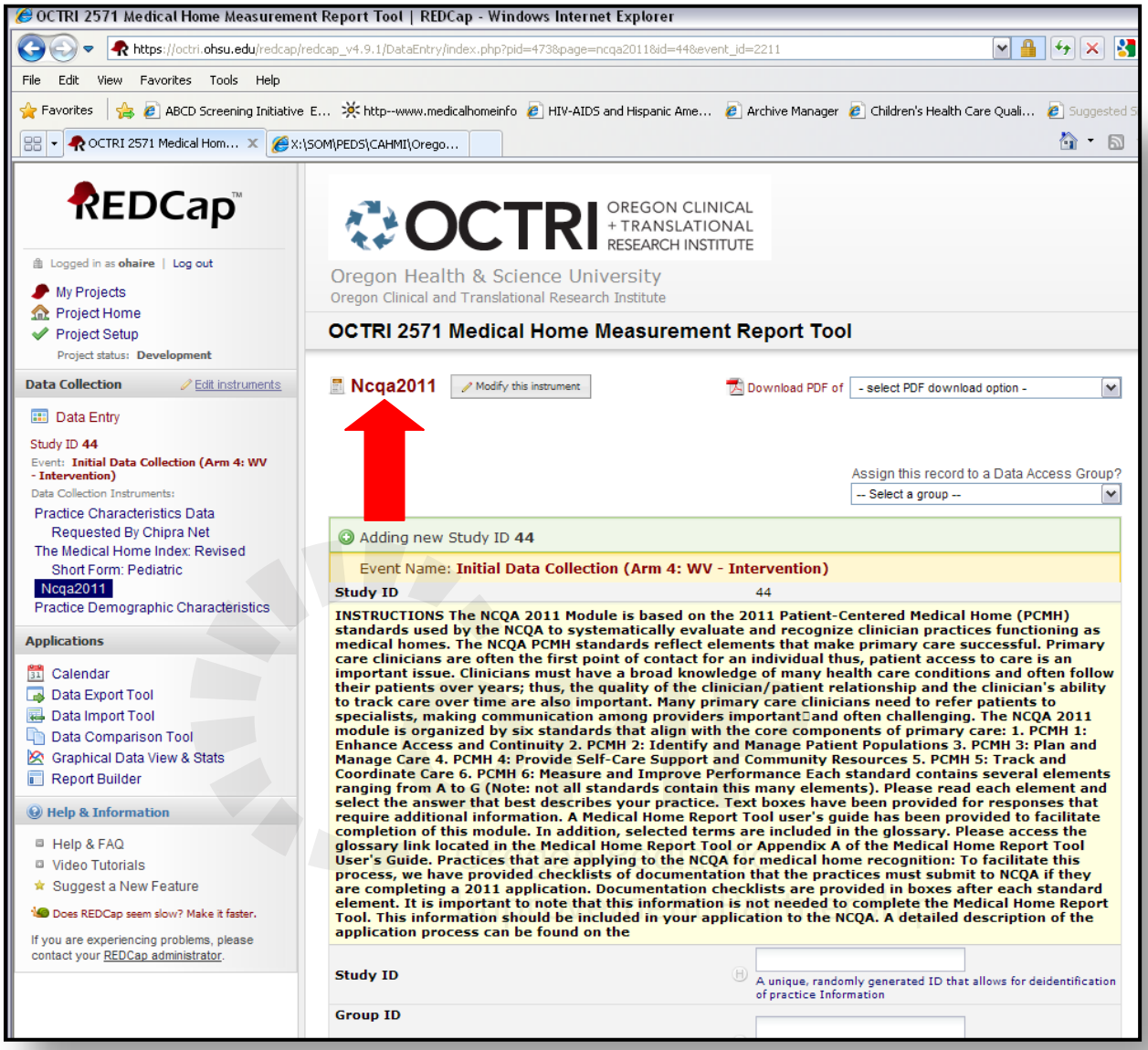
PRACTICE CHARACTERISTICS



MHI:RSF



NCQA PCMH 2011



ADDITIONAL ITEMS: AK SPECIFIC

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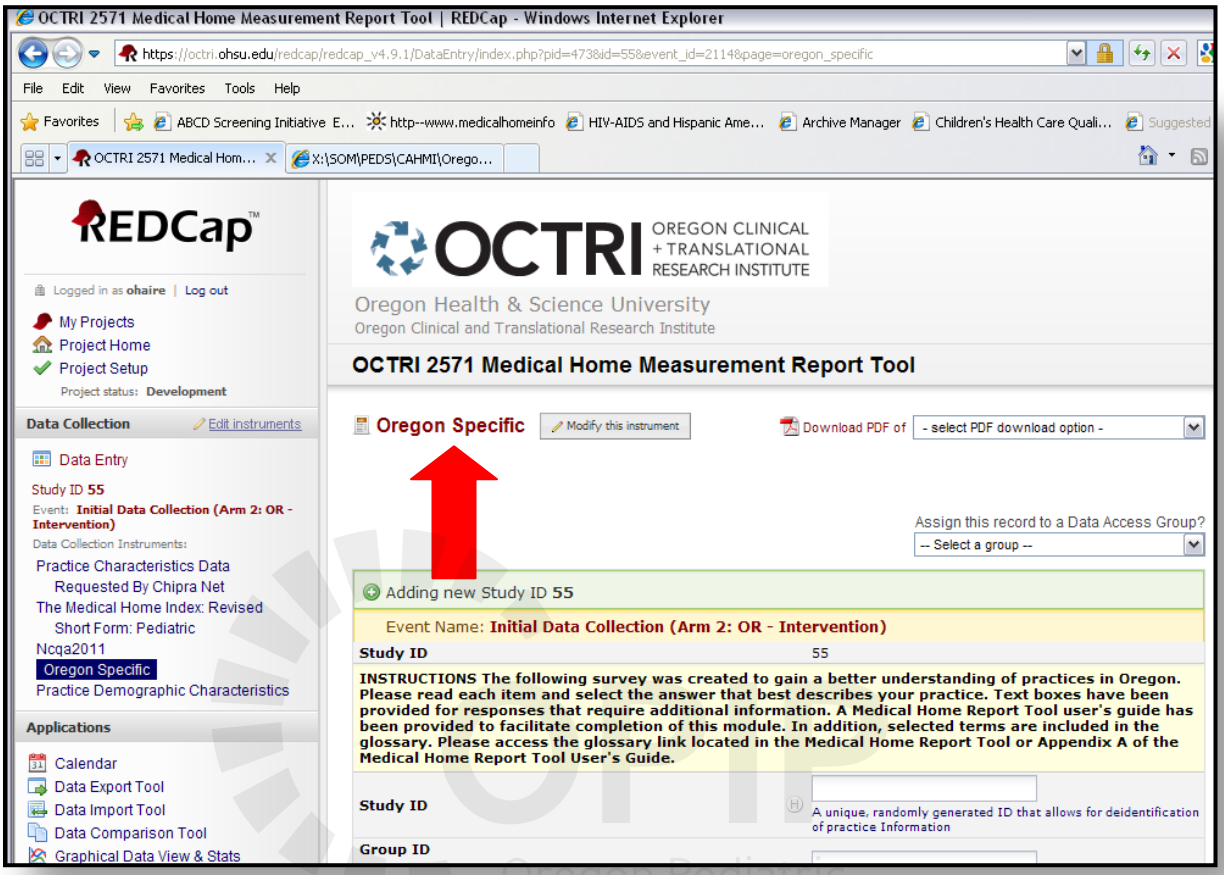
ADDITIONAL ITEMS: OR SPECIFIC

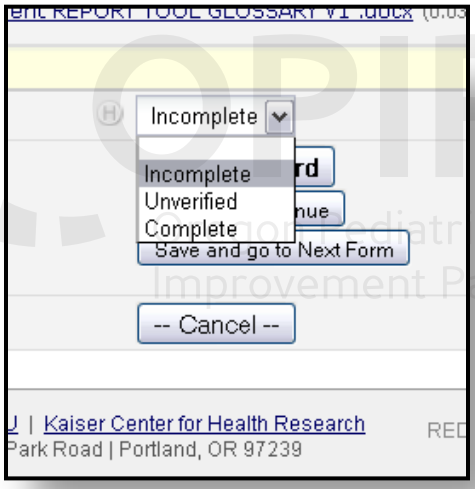


Oregon Pediatric Improvement Partnership

SAVING DATA

- Once you open a form, enter the data, you will need to go to the bottom of the form to save the information.

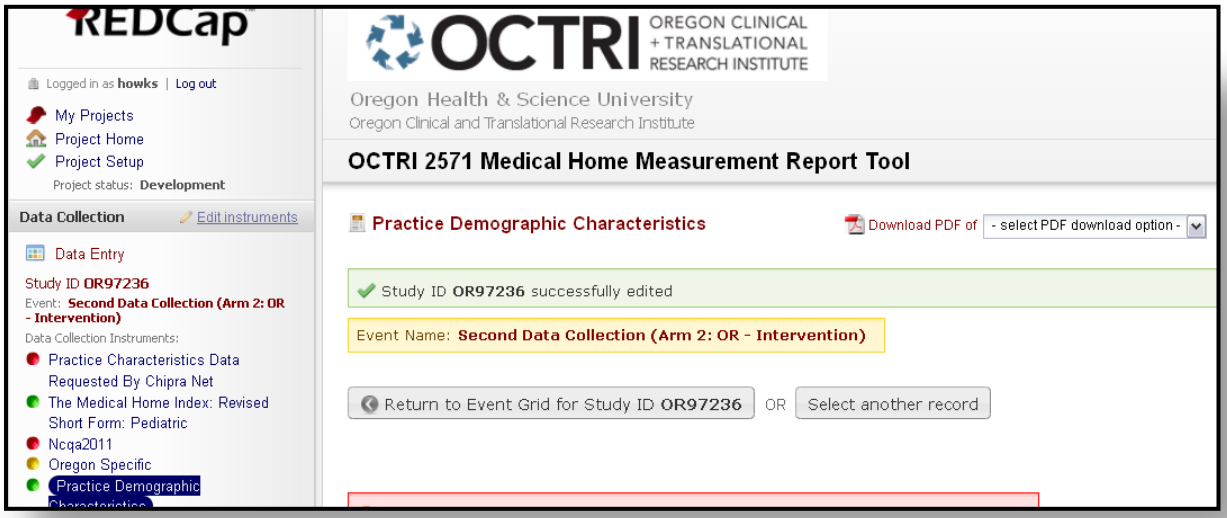
- Choose Incomplete if you have additional data to enter.
- Choose Unverified if you are ready to submit the data.



- Then choose Save Record – saves the record and exits out of the form; Save and Continue – saves the record and let's you continue to add data; or Save and go to Next Form – saves the record and takes you to the next form on the list.

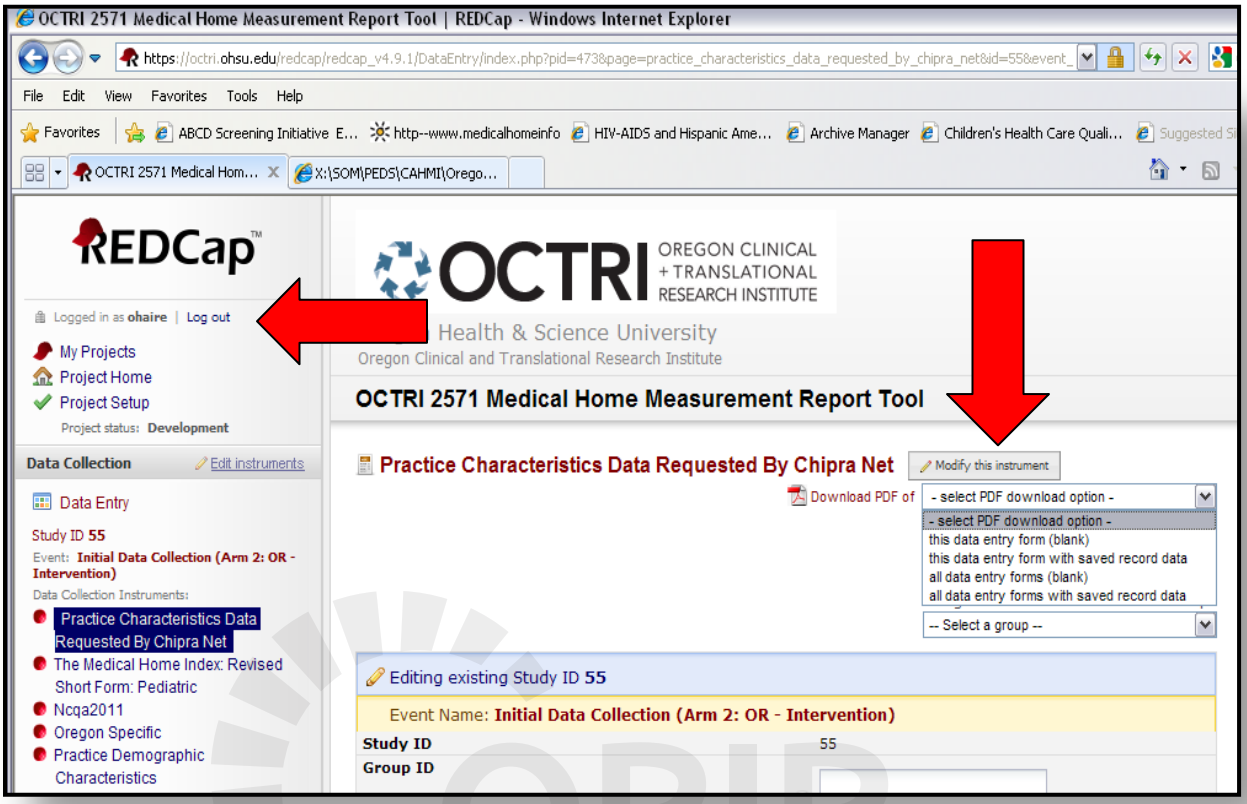
- **Save this information frequently. You can always go back and edit or update the information. If you exit without saving the record information, all data that you entered will be lost.**

- You will be taken back to the screen of the module where you were entering data:



Please notice, in the left hand menu, all of the available forms are listed with circles of different colors next to them. Green means "Complete" was chosen in the previous step. Yellow means Unverified was chosen in the previous step, and Red mean Incomplete was chosen in the previous step.

PRINTING / DOWNLOADING PDFs



- In <u>all</u> of the modules, on the top right, you can select to download each module's forms as a pdf version that can exported with the data that you have entered or as a blank form.

LOGGING OUT

- To log out, click the Log Out text in the upper left corner of the REDCap Screen.
- Please ensure that you have saved your work before logging out!

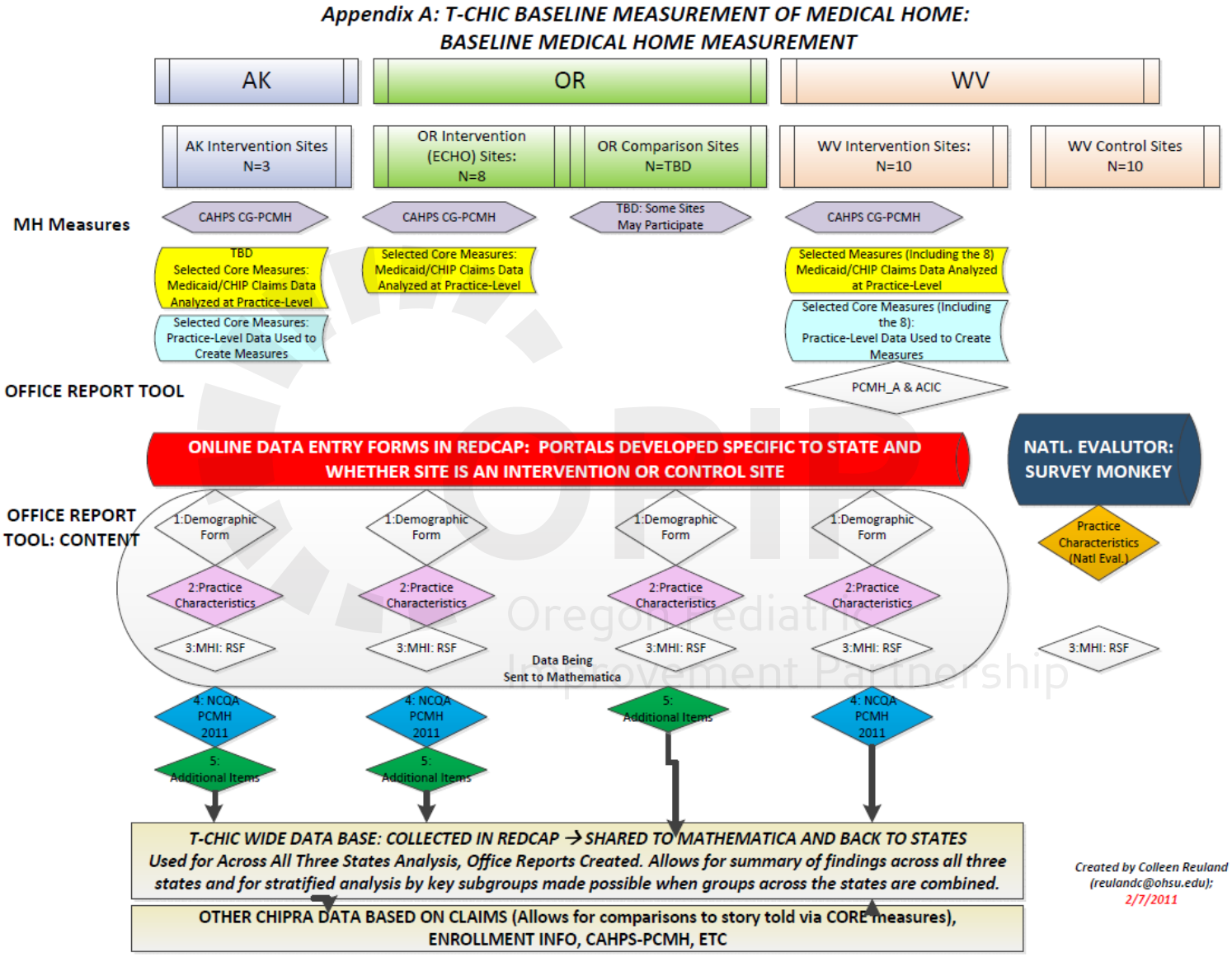

Appendix A: T-CHIC BASELINE MEASUREMENT OF MEDICAL HOME:
BASELINE MEDICAL HOME MEASUREMENT
AK
OR
WV
AK Intervention Sites N=3
OR Intervention (ECHO) Sites: N=8
OR Comparison Sites N=TBD
WV Intervention Sites: N=10
WV Control Sites N=10
MH Measures
CAHPS CG-PCMH
CAHPS CG-PCMH
TBD: Some Sites May Participate
CAHPS CG-PCMH
TBD
Selected Core Measures: Medicaid/CHIP Claims Data Analyzed at Practice-Level
Selected Core Measures: Practice-Level Data Used to Create Measures
Selected Core Measures: Medicaid/CHIP Claims Data Analyzed at Practice-Level
Selected Measures (Including the 8) Medicaid/CHIP Claims Data Analyzed at Practice-Level
Selected Core Measures (Including the 8): Practice-Level Data Used to Create Measures
PCMH_A & ACIC
OFFICE REPORT TOOL
ONLINE DATA ENTRY FORMS IN REDCAP: PORTALS DEVELOPED SPECIFIC TO STATE AND WHETHER SITE IS AN INTERVENTION OR CONTROL SITE
NATL. EVALUTOR: SURVEY MONKEY
OFFICE REPORT TOOL: CONTENT
1:Demographic Form
2:Practice Characteristics
3:MHI: RSF
Practice Characteristics (Natl Eval.)
Data Being Sent to Mathematica
4: NCQA PCMH 2011
5: Additional Items
T-CHIC WIDE DATA BASE: COLLECTED IN REDCAP → SHARED TO MATHEMATICA AND BACK TO STATES
Used for Across All Three States Analysis, Office Reports Created. Allows for summary of findings across all three states and for stratified analysis by key subgroups made possible when groups across the states are combined.
OTHER CHIPRA DATA BASED ON CLAIMS (Allows for comparisons to story told via CORE measures), ENROLLMENT INFO, CAHPS-PCMH, ETC
Created by Colleen Reuland (reulandc@ohsu.edu); 2/7/2011

Figure 1: T-CHIC MEDICAL HOME OFFICE REPORT MEASUREMENT TOOL: Data Update Process

Steps for Updating Data

Step 1:
Review Modules 3 – 4

Step 2:
Answer Updated Items from Modules 3-4 in the Users' Guide (On Paper)

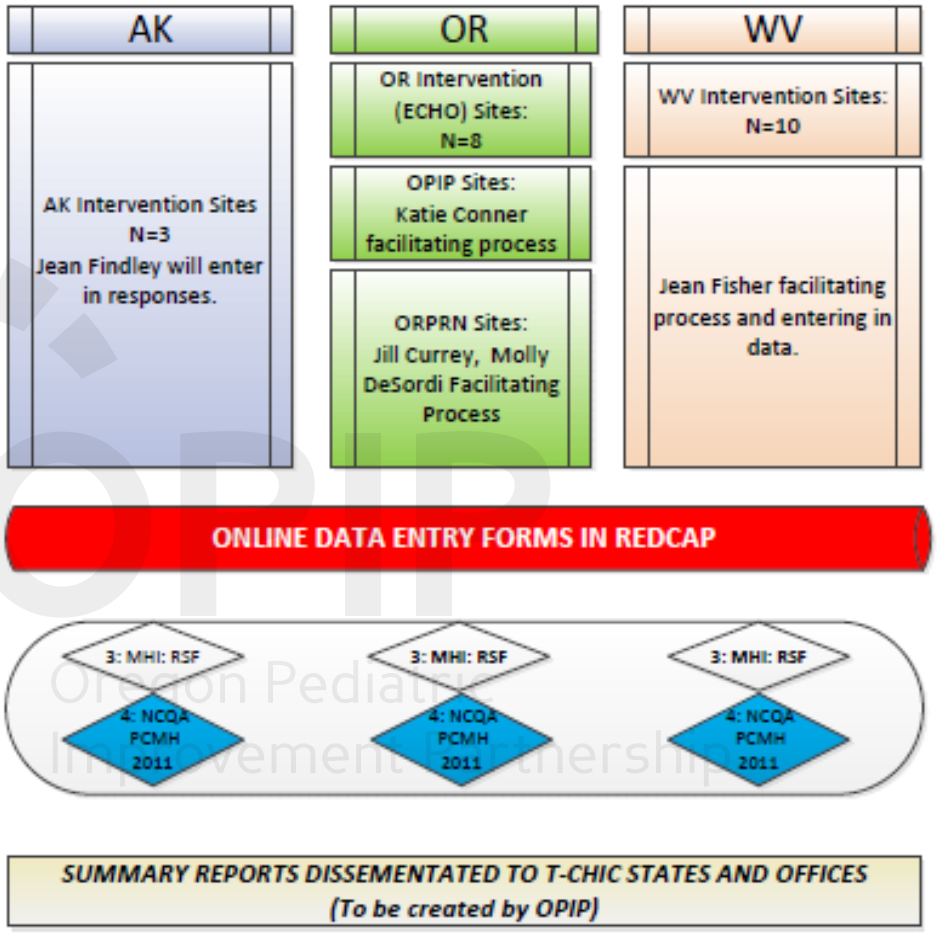
Step 3:
Review Completed Answers with the Full Office Team to Ensure Consensus and Accuracy of Answers

Step 4:
Login to REDCAP using User Name

Step 5:
Enter Data into REDCap
-- Enter only updated data into "Second Data Collection"
-- Proposal is to update every 6 months
-- Updated data (entered in August/September 2012) should reflect office systems/processes after initiation of quality improvement activities for the TCHIC Medical Home Improvement Project.

Step 6:
Once data has been entered, contact Amber Laurie, lauriea@ohsu.edu.

Step 7:
Summary Reports Provided Back to T-CHIC States & Participating Offices



UPDATED 8/15/12

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APPENDIX C: MEDICAL HOME MEASUREMENT REPORT TOOL GLOSSARY

Advance Care Planning	Practice guidance and documentation of patient/family preferences for care at the end of life or for patients who are unable to speak for themselves.
Advance Directive	A document in which patients can explain the type and extent of health care services they prefer if they become unable to make medical decisions. The document may identify another person who can make those decisions on behalf of the individual. Such medical care could include routine treatments and life-saving methods. Advance directives are frequently called living wills.
Allergy	An adverse reaction to a substance.
American Academy of Pediatrics Medical Home Concept	**2002** AAP Policy Statement can be found at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;110/1/184.pdf **2007** ***Introduction*** The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. ***Principles*** ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they

need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care

- planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of

	clinical data using technology. • It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). • It should recognize case mix differences in the patient population being treated within the practice. • It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. • It should allow for additional payments for achieving measurable and continuous quality improvements. **Background of the Medical Home Concept** The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).
Children with Special Health Care Needs (CSHCN)	Children with special health care needs are defined by the US Maternal and Child Health Bureau as those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997).
CHIP	The Children's Health Insurance Program (CHIP) provides free or low-cost health coverage for more than 7 million children up to age 19. CHIP covers U.S. citizens and eligible immigrants.
Chronic Condition Management (CCM):	CCM acknowledges that children and their families may require more than the usual well child, preventive care, and acute illness interventions. CCM involves explicit changes in the roles of providers and office staff aimed at improving: 1) Access to needed services 2) Communication with specialists, schools, and other resources, and 3) Outcomes for patients, families, *practices*, employers and payers.
Clinic Address	The address of the current, physical location of your practice. For multi-site practices, the location where T-CHIC

	quality improvement activities are being implemented, the primary practice location or the site where pediatric patients are seen for primary care.
Critical Factor	A factor identified as central to the concept being assessed within particular elements and is required for practices to receive more than minimal or, for some factors, any points.
Demographic Information	Information that includes (at least) ethnicity, gender, marital status, date of birth, type of work, hours of work and preferred language.
Direct Patient Care	Care of a patient provided personally by a health care staff member. Direct patient care may involve any aspects of the health care of a patient, including treatments, counseling, self-care, patient education, and administration of medication.
Direct Project Interaction	If the practice has had any interaction with the CHIPRA/T-CHIC project staff t has had direction project interaction. (E.g. if a comparison site completed the medical home office report tool, please select the following answer: "Selected comparison practice with direct project interaction.)
Diagnosis	A problem list of a condition, injury or other health issue.
Documented Process	Written statements describing procedures. Statements may include protocols or other documents that describe actual processes or blank forms the practice uses in work flow (e.g., referral forms, checklists, flow sheets).
Electronic Exchange of Information	An electronic exchange of health information (including diagnostic test results, problem list, medication lists, medication allergies) is limited to information that exists electronically in or is accessible from the EHR technology. Form and format of information that is provided to a care facility should be human readable and on an electronic media or through some other electronic means such as a patient portal, PHR, CD, USB, etc.
Electronic Medical Record (EMR) or Electronic Health Record	An Electronic Health Record (EHR) / EMR is an electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.
Electronic Clinical	An electronic copy of health information (including diagnostic test results, problem list, medication lists, medication

Summary	allergies) is limited to information that exists electronically in or is accessible from the EHR technology. Form and format of information that is provided to the patient should be human readable and comply with the HIPAA Privacy Rule. The media could be any electronic form such a patient portal, PHR, CD, USB, etc. Providers are expected to make reasonable accommodations for patient preference. Provision of physical electronic media could be mailed (http://www.cms.gov/EHRIncentivePrograms) .
Emergency Admission	An unscheduled medical or behavioral health care event that results in an emergency room visit or hospital admission.
Evidence-Based Guidelines	Clinical practice guidelines based on scientific evidence; or in the absence of scientific evidence, professional standards; or in the absence of professional standards, expert opinion. See **practice guidelines**.
Example	A document, report or prepared material that illustrates implementation of systems or processes by the practice.
Factor	A scored item in an element. For example, an element may require the organization to demonstrate that a specific document includes four items. Each item is a factor.
Family-Centered Care	U.S. Maternal Child Health Bureau's definition/conceptualization of family-centered care assures the health and well being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-centered care is the standard of practice that results in high quality services.
Fee-for-Service	Traditional (indemnity) health insurance where you and your plan each pay a portion of your health expenses, usually after you meet a yearly deductible. In most cases, you can choose any physician, hospital, or other provider (non-network based coverage).
Health Maintenance Organization	A form of managed care in which you receive all of your care from participating providers. You usually must obtain a referral from your primary care physician before you can see a specialist.
Important Condition	A condition, including an unhealthy behavior, substance abuse or a mental health issue, with evidence-based clinical guidelines that affect a large number of people or consumes a disproportionate amount of health care resources.
Lab	The CDC definition of clinical laboratory (from the Public Health Service Act SEC 353) -- A facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical,

	cytological, pathological and other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention and treatment of any disease of impairment of, or the assessment of health of human beings.
Learning Collaborative	In a learning collaborative, clinical staff work together to redesign their systems to become more patient-focused and efficient.
Materials	Prepared information that the practice provides to patients, including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.
Meaningful Use Requirements	The CMS implementation of the American Recovery and Reinvestment Act (ARRA) of 2009 (Recovery Act) provides incentive payments to eligible professionals for adopting and demonstrating meaningful use of certified HER technology. Criteria for meaningful use are electronically capturing health information in a coded format, using the information to track key clinical conditions, communicating the information for care coordination and reporting clinical quality measures and public health information. Stage 1 has 25 requirements, including *15 Core Requirements* that must all be met and *10 Menu Requirements,* 5 of which must be met.
Medical Home	A medical home is a community-based primary care setting which provides and coordinates high *quality*, planned, patient/family-centered: health promotion (acute, preventive) and *chronic condition management* (© CMHI, 2006).
Multi-site group or practice	A group with multiple practice sites that provide standardized systems across the practices. The sites share an electronic record system and standardized policies and procedures across all of the practice sites. Practice sites do not all have to be the same specialty or the same size.
Must Pass Elements	Designated elements that a practice must pass at a score of ≥50% to achieve NCQA PCMH 2011 Recognition.
NCQA PCMH 2011	The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.
Office Policies	Definite courses of action adopted for expediency; "the way we do things"; these are clearly articulated to and

	understood by all who work in the office environment.
Pay-for-Performance	Pay-for-performance (P4P) programs are designed to offer financial incentives to physicians and other health care providers to meet defined quality, efficiency, or other targets.
PCCM	PCCM is a managed fee-for-service arrangement, utilizing a network of primary care physicians and health care providers to serve as the medical home for Medicaid patients.
Physician Extender	A physician extender is a health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.
Population Management	Assessing and managing the health needs of a patient population rather than individual patients, such as defined groups of patients (e.g., patients with specific clinical conditions such as diabetes, patients needing immunizations).
Practice	One or more clinicians at a single geographic location who practice together and provide patient care at this location.
Practice-Based Care Coordination	Care and services performed in partnership with the family and providers by health professionals to: 1) Establish family-centered community-based Medical Homes for ***CSHCN*** and their families. -Make assessments and monitor child and family needs -Participate in parent/professional practice improvement activities 2) Facilitate timely access to the ***Primary Care Provider*** (***PCP***), services and resources -Offer supportive services including counseling, education and listening -Facilitate communication among PCP, family and others 3) Build bridges among families and health, education and social services; promotes continuity of care -Develop, monitor, update and follow-up with care planning and care plans -Organize wrap around teams with families; support meeting recommendations and follow-up 4) Supply/provide access to referrals, information and education for families across systems. -Coordinate inter-organizationally -Advocate with and for the family (e.g. to school, day care, or health care settings) 5) Maximize effective, efficient, and innovative use of existing resources -Find, coordinate and promote effective and efficient use of current resources -Monitor outcomes for child, family and practice
Practice Guidelines	Systematically developed descriptive tools or standardized protocols for care to support clinician and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a

	formal process and are based on authoritative sources that include clinical literature and expert consensus.
Practice Team	A group of clinical and nonclinical staff (e.g., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) who manage patient care and population health by interacting with patients and working to achieve stated objectives.
Primary Caregiver	An individual who provides day-to-day care for a patient and must receive instructions about the patient's care.
Primary Care Provider	Physician or pediatric nurse practitioner who is considered the main provider of health care for the child.
Public Insurance	Public insurance includes only Medicaid or CHIP insurance. This does not include Medicare insurance.
Quality	Quality is best determined or judged by those who need or who use the services being offered. Quality in the medical home is best achieved when one learns what children with special health care needs and their families require for care and what they need for support. Health care teams in partnership with families then work together in ways that enhance the capacity of the family and the practice to meet these needs. Responsive care is designed in ways which incorporate family needs and suggestions. Those making practice improvements must hold a commitment to doing what needs to be done and agree to accomplish these goals in essential partnerships with families.
Rapid Cycle Improvement - PDSA	This is a tool for accelerating improvement. The Plan-Do-Study-Act (PDSA) cycle guides the test of a change to determine if the change is an improvement.
Records or Files	Actual patient medical files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element.
Registry	A searchable list of patient data that the practice proactively uses to assist in patient care.
Reports	Aggregated data showing evidence of action; may include manual and computerized reports.
Risk Factors	Behaviors, habits, age, family history or other factors that may increase the likelihood of poor health outcomes.
Rural	A place with a density less than 500 people per square mile and is based on a definition used by the U.S. Department of Justice (http://www.justice.gov/ndic/pubs27/27612/appenda.htm).

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Sample	A statistically valid representation of the whole.
Shared Medical Appointment	An appointment where multiple patients meet in a group setting for follow-up or routine care.
Staff Model HMO	A model of managed care organizations where physicians are salaried employees or partners of the HMO, and may also receive bonuses, incentive payments or share in profits. Typically, they employ physicians in all the common specialties needed to deliver comprehensive care, though they may also subcontract to specialists for infrequently needed services.
Suburban	• A place no more than 30 miles from urban areas. **OR** • A place with a density greater than or equal to 500 people per square mile and less than 2,000 people per square mile. This is based on a definition used by the U.S. Department of Justice (http://www.justice.gov/ndic/pubs27/27612/appenda.htm).
Telemedicine	Telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. The electronic communication means the use of interactive telecommunication equipment that includes, at a minimum, audio and video equipment. Telemedicine is viewed as a cost-effective alternative to the more traditional, face-to-face way of providing medical care.
Third Available Appointment	A measurement of the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on the clinician's schedule.
Treatment Plan	A written action plan based on assessment data that identifies a patient's clinical needs, the strategy for providing services to meet those needs, the treatment goals and objectives.
Tribe	An Indian tribe is any tribe, band, nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. In NAGPRA, the term "Indian tribe" includes Native Alaskan villages and corporations. Alaska Native villages and corporations include those groups or communities defined in, or established pursuant to, the Alaska Native Claims

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	Settlement Act.
TRICARE	TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide.
United States Maternal and Child Health Bureau Family Centered Care	Family-centered care assures the health and well being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-centered care is the standard of practice that results in high quality services.
Urban	• A place with a density greater than or equal to 2,000 people per square mile, **OR** • A place that has a total population greater than or equal to 100,000 people and a density greater than or equal to 2,000 people per square mile, **OR** • A place that has a total population greater than or equal to 200,000 people. This is based on a definition used by the U.S. Department of Justice (http://www.justice.gov/ndic/pubs27/27612/appenda.htm).
Vulnerable Populations	Those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ definition). Vulnerable populations include people with multiple comorbid conditions or who are at high risk for frequent hospitalizations or ER visits.
Visit	A health care visit is a scheduled or structured contact/encounter with a health care professional. Electronic/telemedicine/phone contact that includes **only** advice is not considered to be electronic/telemedicine/phone visits.