

# Draft Standards for Patient-Centered Medical Home (PCMH) 2011

PCMH 2011 Elements and Standards		Summary of Changes and Explanation
<b>PCMH 1: Access and Continuity</b>		
<b>1A: Access During Office Hours</b>	<p>The practice has a process and demonstrates that it:</p> <ol style="list-style-type: none"> <li>1. Provides same day appointments for routine and urgent care based on practice’s triage of patients</li> <li>2. Provides timely clinical advice by phone or e-mail during office hours</li> <li>3. Documents phone or email clinical advice in the patient record</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Access policies and results of monitoring by practice of compliance with their policies; ‘timely’ is defined by the practice.</p>	<p><b>Deleted or moved to another element:</b></p> <ul style="list-style-type: none"> <li>• Scheduling with a personal clinician (moved)</li> <li>• Coordinating visits with multiple clinicians (deleted)</li> <li>• Scheduling patients based on patient request (deleted)</li> <li>• Providing language services (moved)</li> <li>• Identifying health insurance resources (moved)</li> </ul>
<b>1B: Access After Hours</b>	<p>The practice has a process and demonstrates that it:</p> <ol style="list-style-type: none"> <li>1. Provides appointment times for routine and urgent care outside typical office hours (e.g. evening or Saturday appointments)</li> <li>2. Provides continuity of medical record information for after hours care and advice when office is not open (e.g. standing arrangement for after-hours care at specific facility, having records available to on-call staff)</li> <li>3. Provides interactive clinical advice (phone, email) when the office is closed</li> <li>4. Documents after hours phone or email clinical advice in the patient record</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Access policies and results of monitoring by practice of compliance with their policies</p>	<p><b>New element</b></p> <p>Separate focus on after hours care</p> <p><b>Added the following factors:</b></p> <ul style="list-style-type: none"> <li>• Appointments outside typical office hours</li> <li>• Arrange for after hours care</li> <li>• Document after hours call in record</li> </ul>

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<p><b>1C: Electronic Access</b></p> <p>The practice demonstrates that it offers electronic access to information and services:</p> <ol style="list-style-type: none"> <li>1. Provides patients/families with secure electronic access to medical record information</li> <li>2. Provides electronic copy of health information upon request</li> <li>3. Provides electronic clinical summaries for patients/families at each office visit</li> <li>4. Provides electronic communication between patients/families and clinicians via secure email or patient portal</li> <li>5. Provides patients/families with an interactive Web site to schedule appointments or order prescription refills</li> <li>6. Provides patients/families with an interactive Web site that enables requesting referrals, or test results.</li> </ol> <p><b>Scoring:</b> Based on number of factors met  <b>Documentation:</b> Screen shots from electronic system</p>	<p>Electronic access separated from appointment or phone access</p>	
<p><b>1D: Continuity</b></p> <p>Practice provides continuity of care for patients including:</p> <ol style="list-style-type: none"> <li>1. A process to assign patient/family to a personal clinician or team</li> <li>2. Maintaining record of patient /family choice of clinician/team in the medical record</li> <li>3. Monitoring proportion of patient visits that occur with assigned clinician/team</li> </ol> <p><b>Scoring:</b> Based on number of factors met  <b>Documentation:</b> Policy for factor 1; example/report/screen shot for factor 2; report for factor 3</p>	<p><b>New element</b></p> <p>Emphasizes team-based care and continuity with the same clinician and team</p>	
<p><b>1E: Patient/Family Partnership</b></p> <p>Practice discusses with and distributes written information to patients and their families on the role of the medical home, including responsibilities of the practice and of the patient/family:</p> <ol style="list-style-type: none"> <li>1. Explains what a medical home is and how it functions (e.g., practice is concerned about the entire range of a patient’s health, patient self-management support)</li> <li>2. Explains how to use this medical home practice (e.g., hours, when and where to seek afterhours care, getting information by phone or email)</li> <li>3. Explains the role of the patient in the medical home (e.g., telling practice about all medications, providing practice with medical history, health status, recent test results and self-care information)</li> </ol>	<p><b>New element</b></p> <p>Encourages communication about the responsibilities of the practice and those of the patient</p>	

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	<p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Patient brochure, written statement, video or Website information on patient and practice responsibilities</p>	
<p><b>1F: Culturally and Linguistically Appropriate Services (CLAS)</b></p>	<p>Practice engages in activities to understand and meet the cultural and linguistic needs of its patients :</p> <ol style="list-style-type: none"> <li>1. Assesses the racial and ethnic diversity of its patient population</li> <li>2. Assesses the language needs of its patient population</li> <li>3. Provides materials in the languages of its patients</li> <li>4. Provides competent interpretation or bilingual services to meet the language needs of its patients</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Report; written policy/process; materials</p>	<p><b>New element</b></p> <ul style="list-style-type: none"> <li>• Highlights an important issue</li> <li>• Consolidates requirements from prior version of standards</li> <li>• Adds provision of materials geared to patient level of understanding</li> </ul>
<p><b>1G: Practice Organization</b></p>	<p>The care team manages patient care in the following ways:</p> <ol style="list-style-type: none"> <li>1. Defines roles for all team members including clinical and non-clinical practice staff.</li> <li>2. Has regular team meetings and a communication process (e.g. daily huddle, email or instant messaging, messages in chart)</li> <li>3. Uses standing orders for medication refills, tests, routine preventive services</li> <li>4. Care team staff are assigned and trained to coordinate care (tests, referrals, community-based services)</li> <li>5. Care team staff assigned and trained to support patient/family in self-management, self-efficacy and behavior change (e.g. weight reduction, smoking cessation, stress reduction)</li> <li>6. Care team staff are assigned and trained to manage populations of patients</li> <li>7. Care team staff assigned and trained in communication skills with vulnerable populations</li> <li>8. Care team is involved in performance evaluation and improvement.</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Job descriptions, protocols, written standing orders</p>	<p><b>Moved</b></p> <p>From care management standard to reflect broader intent of this element.</p> <p><b>Added</b></p> <ul style="list-style-type: none"> <li>• Regular team communication</li> <li>• Team trained to coordinate care, in patient self-management, in population management, in communicating with vulnerable populations and in performance measurement and quality improvement</li> </ul>

PCMH 2011 Elements and Standards		Summary of Changes and Explanation
<b>PCMH 2: Identify and Manage Patient Populations</b>		
<b>2A: Basic Data</b>	<p>Practice has an electronic system with searchable patient information:</p> <ol style="list-style-type: none"> <li>1. DOB</li> <li>2. Gender</li> <li>3. Marital status (N/A for pediatric practices)</li> <li>4. Race and ethnicity*</li> <li>5. Language</li> <li>6. Email address</li> <li>7. Current and past diagnoses</li> <li>8. Dates of previous clinical visits</li> <li>9. Legal guardian/health care proxy</li> <li>10. Presence of advance directives</li> <li>11. Health insurance information</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Reports from the electronic system showing % patients seen in a three month period for whom the information is populated</p>	<p><b>Deleted</b></p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Internal ID</li> <li>• External ID</li> <li>• Emergency contact</li> <li>• Address</li> <li>• Billing codes</li> </ul> <p><b>Moved to another element</b> Preferred method of communication</p> <p>*Race/ethnicity data can be collected in any format as long as the data can roll up to Office of Management and Budget (OMB) categories [see end of PCMH 2011 table*]</p>
<b>2B: Searchable Clinical Data</b>	<p>Practice has an electronic system(s) that captures the following clinical patient information in searchable data fields</p> <ol style="list-style-type: none"> <li>1. Uses nationally standardized codes for patients, clinicians and clinical data, including medication and allergy data</li> <li>2. Documentation of age-appropriate preventive services [NCQA will specify based on USPSTF recommendations]</li> <li>3. Documentation of results of screenings and risk factor assessments</li> <li>4. Allergies and adverse reactions</li> <li>5. Blood pressure with date of update</li> <li>6. BMI (N/A for pediatric practices)</li> <li>7. Length, weight, head circumference plotted on growth chart for ≤ 2 years of age (N/A for adult practices)</li> </ol>	<p><b>Added</b></p> <ul style="list-style-type: none"> <li>• Documentation of screening results in the medical record</li> <li>• Use of standardized codes</li> <li>• Integration of data into patient record</li> </ul> <p><b>Deleted or moved to another element</b></p> <ul style="list-style-type: none"> <li>• Pathology reports (deleted)</li> <li>• Advance directives (moved)</li> <li>• List of prescription medications,</li> </ul>

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	<p>8. BMI percentile plotted on growth chart for 2 – 17 years (N/A for adult practices)</p> <p>9. Lists of prescription medications with date of updates</p> <p>10. Lists of over-the-counter medications with date of updates</p> <p>11. Lists of supplements and alternative therapies with date of updates</p> <p>12. Laboratory test results</p> <p>13. Imaging results</p> <p>14. Care in other facilities and dates</p> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Reports from the electronic system showing % patients seen in a 3 month period for whom the information is populated</p>	<p>over-the-counter medications, supplements (moved)</p>
<b>2C: Comprehensive Health Assessment</b>	<p>Practice conducts and documents a comprehensive health assessment for all patients to understand their risks and needs of information that includes the following:</p> <ol style="list-style-type: none"> <li>1. Family/social/cultural characteristics</li> <li>2. Communication needs (vision/hearing)</li> <li>3. Medical history of patient and family</li> <li>4. Advance care planning (N/A for pediatric practices)</li> <li>5. Depression screening for patients with chronic conditions using a standardized tool</li> <li>6. Behaviors (smoking, nutrition, physical activity, dental care) and family risk factors (e.g. second hand smoke)</li> <li>7. Patient and family mental health/substance abuse (stress, alcohol, prescription drug abuse or illegal drug use, maternal depression)</li> <li>8. Developmental/autism screening using a standardized tool (N/A for adult practices)</li> <li>9. Depression screening for adolescents using a standardized tool (N/A for adult practices)</li> <li>10. Functional status</li> </ol> <p><b>Scoring:</b> Based on percent of patients with a specified number of factors met.</p> <p><b>Documentation:</b> Report from electronic system or use the Record Review Workbook. Record Review Workbook is an excel spreadsheet used to collect medical record information on a specified number of patients using NCQA's sampling methodology.</p>	<p><b>New element</b></p>

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<p><b>2D: Using Data for Population Management</b></p> <p>Practice uses basic patient data and clinical data to organize/generate lists of patients and to proactively remind patients or clinicians of services needed related to:</p> <ol style="list-style-type: none"> <li>1. At least three different preventive care services (e.g. well-child visit, immunization, cancer screening)</li> <li>2. A specific medication (e.g., to notify of medication recall)</li> <li>3. Prescription medication refills/compliance</li> <li>4. At least three different chronic/acute care services (e.g. diabetes testing, lab values outside normal range)</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Reports or screen shots showing lists and materials or other documentation illustrating use of data for patient reminders.</p>	<p><b>Deleted</b></p> <ul style="list-style-type: none"> <li>• Patients needing pre-visit planning</li> <li>• Patients needing clinician review or action</li> </ul>	
<b>PCMH 3: Plan and Manage Care</b>		
<p><b>3A: Guidelines for Important Conditions</b></p> <p>The practice adopts and implements evidence-based guidelines for:</p> <ol style="list-style-type: none"> <li>1. First clinically important condition</li> <li>2. Second clinically important condition</li> <li>3. Third clinically important condition</li> </ol> <p>One of the conditions selected by the practice must be a condition related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition.</p> <p><b>Scoring:</b> Based on number of factors met; practices seeking to renew their PCMH recognition must select at least one new condition not present in their initial application.</p> <p><b>Documentation:</b> Workflow organizers or decision support tools demonstrating source of the guidelines and adoption and implementation by the practice.</p>	<p><b>Added/changed</b></p> <p>Expanded accepted list of clinically important conditions</p>	
<p><b>3B: Care Management</b></p> <p>The care team uses the following components of care management support for patients:</p> <ol style="list-style-type: none"> <li>1. Conducts pre-visit planning (e.g. reviews chart before visit, notifies patient of tests needed before the visit)</li> <li>2. Develops an individualized care plan including treatment goals in collaboration with patient that addresses patient’s comprehensive care needs</li> </ol>	<p>Reduced factors and emphasize pre-, post-visit and care planning during visits, evaluation of care and patient self-care</p>	

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<ol style="list-style-type: none"> <li>3. Reviews care plan and assesses progress toward treatment goals at each visit</li> <li>4. Provides patient with clinical summary for each office visit</li> <li>5. Assesses and supports patients in adopting healthy behaviors</li> <li>6. Assesses and arranges or provides treatment for mental health and substance abuse problems</li> <li>7. Follows up with patients when they have not kept important appointments</li> <li>8. Follows up with patients between visits (check on self-care, medication fills, treatment plan, schedules visits, refers for tests/follow-up care)</li> </ol> <p><b>Scoring:</b> Based on percent of patient s with a specified number of factors met.</p> <p><b>Documentation:</b> Report from electronic system or use the Record Review Workbook and written description of the process and materials.</p> <p>Record Review Workbook is an excel spreadsheet used to collect medical record information on a specified number of patients using NCQA’s sampling methodology.</p>	
<p><b>3C: Medication Management</b></p> <p>Practice engages in medication management:</p> <ol style="list-style-type: none"> <li>1. Reviews and reconciles list of medications with patients at each visit, including OTC, RX, herbal therapies/supplements</li> <li>2. Provides patients with information about the reason for the medication they are taking, potential side effects and drug interactions, and consequences of not taking it</li> <li>3. Reviews patient understanding of medication treatment</li> <li>4. Monitors patient fill and refill of prescriptions</li> </ol> <p><b>Scoring:</b> Based on percent of patients with a specified number of factors met.</p> <p><b>Documentation:</b> Report from electronic system or use the Record Review Workbook and written description of the process and materials.</p> <p>Record Review Workbook is an excel spreadsheet used to collect medical record information on a specified number of patients using NCQA’s sampling methodology.</p>	<p>Reorganized and reduced number of factors</p> <p>Focuses on medication management, reconciling medications</p>
<p><b>3D: Electronic Prescribing</b></p> <p>Clinicians in the practice write at least 75% of all prescriptions using electronic prescription reference information at the point of care:</p> <ol style="list-style-type: none"> <li>1. Electronic system is integrated with the patients’ medical records</li> </ol>	<p><b>New element</b></p> <p>Focuses on electronic prescription writing capabilities.</p>

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	<ol style="list-style-type: none"> <li>2. Electronic system connects to pharmacies, pharmacy benefit manager</li> <li>3. Electronic system receives renewal requests electronically</li> <li>4. Electronic system uses patient specific information to generate alerts at the point of care: drug-drug interactions, drug-disease interactions, drug-allergy alerts</li> <li>5. Electronic system alerts prescriber to generic alternatives</li> <li>6. Electronic system alerts prescriber to formulary status</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Report demonstrating the number of prescriptions written electronically; information/screen shots demonstrating capabilities</p>	
<b>PCMH 4: Self- Management Support</b>		
<b>4A: Self-Care Process</b>	<p>Practice conducts activities to support patient/family self-management:</p> <ol style="list-style-type: none"> <li>1. Assesses and tracks patient capacity for and confidence in self-care</li> <li>2. Develops self-care plan in collaboration with patient</li> <li>3. Provides self-monitoring tools or personal health record that enables patients/families to record results in home setting</li> <li>4. Provides or connects patients/families to self-management support programs, including off-site programs</li> <li>5. Provides information on health insurance resources</li> <li>6. Provides information on enabling services (e.g. transportation) resources</li> </ol> <p><b>Scoring:</b> Based on percent of patient s with a specified number of factors met.</p> <p><b>Documentation:</b> Report from electronic system or use the Record Review Workbook and written description of the process and materials.</p> <p>Record Review Workbook is an excel spreadsheet used to collect medical record information on a specified number of patients using NCQA’s sampling methodology.</p>	<p><b>Added</b></p> <ul style="list-style-type: none"> <li>• Provides patient with a self-care plan</li> <li>• Information on enabling services</li> </ul>
<b>PCMH 5: Track and Coordinate Care</b>		
<b>5A: Test Tracking and Follow-up</b>	The practice systematically tracks tests and follows up:	<b>Added/changed</b>

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	<ol style="list-style-type: none"> <li>1. Tracks all lab tests until results are available</li> <li>2. Flags overdue lab results</li> <li>3. Tracks all imaging tests until results are available</li> <li>4. Flags overdue imaging results</li> <li>5. Flags abnormal lab and imaging results</li> <li>6. Follows up with patients for normal and abnormal lab and imaging results</li> <li>7. Follows up with inpatient facility on newborn hearing screening/ metabolic screening</li> <li>8. Electronic communication with facilities to order and retrieve results from source</li> <li>9. Flags duplicate lab and imaging tests</li> <li>10. Orders lab and imaging tests by electronic communication with facilities</li> <li>11. Uses electronic system to retrieve lab and imaging results</li> <li>12. Integrate lab and imaging test results into the medical record.</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Reports and materials or other documentation illustrating test tracking system.</p>	<ul style="list-style-type: none"> <li>• Merged Test Tracking and Follow-Up and Electronic System for Managing Tests</li> <li>• Integration of lab and imaging test results into the medical record</li> </ul> <p><b>Deleted</b> Generates alerts for appropriateness of tests ordered</p>
<b>5B: Referral Tracking and Follow-up</b>	<p>The practice coordinates referrals designated as important (include referrals to medical specialists, mental health and substance abuse services) through the following:</p> <ol style="list-style-type: none"> <li>1. Uses an electronic system to track referrals</li> <li>2. Provides the patient and referral clinician with the reason for the consultation and pertinent clinical findings</li> <li>3. Tracks the status of the referral, including the timing for the referred service</li> <li>4. Documents the referral dates in medical record</li> <li>5. Follows-up to obtains a report back from the referral clinician</li> <li>6. Asks patients about self-referrals and requests reports from the clinician</li> <li>7. Has agreements with specialists if co-management is needed</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Reports and materials or other documentation illustrating referral tracking system.</p>	<p><b>Added/revised</b></p> <ul style="list-style-type: none"> <li>• Revised to clarify language</li> <li>• Referrals to behavioral/mental health specialists</li> <li>• Asks patient about self-referrals and obtaining results</li> <li>• Generates reports on referrals</li> </ul>
<b>5C: Coordination</b>	The practice on its own or in conjunction with an external organization systematically:	<b>Added</b>

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<p><b>with Facilities/Care Transitions</b></p>	<ol style="list-style-type: none"> <li>1. Has a process to identify patients with an unscheduled hospital admission or emergency department visit</li> <li>2. Sends clinical information to hospital or emergency department with patients as soon as possible</li> <li>3. Contacts patients with an unscheduled hospital admission or emergency department visit within an appropriate timeframe after being notified (defined in the practice's policies).</li> <li>4. Has formal agreement with hospitalists when they provide care to patients</li> <li>5. For pediatric patients transitioning from pediatric care to adult care develops a written care plan in collaboration with patient and family (plan, track, manage with checklists, medication reconciliation, care plans for patient and clinician (includes behavioral health) (N/A for adult patients)</li> <li>6. Documents hospitalization dates in medical record</li> <li>7. Documents emergency room visit dates in medical record</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Varies by factor; includes documented processes, examples of information exchange template, formal agreements</p>	<p>Formal agreement with hospitalists and facilities</p> <p><b>Deleted</b></p> <ul style="list-style-type: none"> <li>• Reviews information from facilities</li> <li>• Coordinates and communicates care with external case manager</li> </ul>
<p><b>5D: Referrals to Community Resources</b></p>	<p>The practice supports patients needing access to community resources as follows:</p> <ol style="list-style-type: none"> <li>1. Maintains a list of key community services agencies with contact information</li> <li>2. Uses a system to track referrals to community services</li> <li>3. Provides patients/families with information about the recommended/available services and a contact for the community agency</li> <li>4. Tracks the status of the referral</li> <li>5. Obtains a report back from the agency with permission of the patient/family</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Materials, example of tracking system, example of information exchange template or request</p>	<p><b>New element</b></p> <p>Consolidates and adds to previous requirements</p>

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<b>PCMH 6: Performance Measurement and Quality Improvement</b>		
<b>6A: Measures of Performance</b>	<p>The practice monitors its performance results in the following ways:</p> <ol style="list-style-type: none"> <li>1. At least three prevention measures</li> <li>2. At least three clinical chronic disease management measures (Note: may be met with RP Recognition (BPRP, DRP, HSRP))</li> <li>3. At least one measure of overuse (e.g. antibiotic use for bronchitis in adults, pharyngitis in children)</li> <li>4. At least three types of utilization or cost data (e.g., hospitalizations, ER visits, referrals to specialists, lab and imaging test referrals)</li> <li>5. The practice obtains performance data for key vulnerable populations (e.g., stratified data for key groups based on race/ethnicity, age, gender, language needs)</li> <li>6. Clinicians receive data on their own performance</li> <li>7. Clinicians receive practice-level performance data</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Reports showing summary practice performance and individual clinician performance; blinded communications demonstrating distribution of results.</p>	<p><b>Added/changed</b></p> <ul style="list-style-type: none"> <li>• Expanded number of measures required for each factor</li> <li>• Factor 5 aimed at collecting and looking at stratified quality data for vulnerable groups</li> </ul> <p><b>Deleted</b></p> <ul style="list-style-type: none"> <li>• Service data is addressed through the patient survey</li> <li>• Patient safety issues infrequently collected by Recognized practices and addressed through medication management</li> </ul>
<b>6B: Patient/Family Feedback</b>	<p>The practice obtains feedback from patients and families to inform quality improvement activities on at least three of the following categories :</p> <ul style="list-style-type: none"> <li>• Access</li> <li>• Communication</li> <li>• Coordination</li> <li>• Self-management support</li> <li>• Whole person orientation</li> <li>• Comprehensiveness</li> <li>• Shared decision making</li> </ul> <ol style="list-style-type: none"> <li>1. The practice conducts a survey to evaluate patient experiences</li> </ol>	<p><b>Added/changed</b></p> <p>Revised and strengthened</p> <p><i>** NCQA is working with the AHRQ CAHPS team to develop a Medical Home version of CAHPS Clinician and Group survey)</i></p>

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<p>2. The practice obtains feedback from patients on all categories (not just three)</p> <p>3. The practice uses the Medical Home survey tool**</p> <p>4. The practice obtains feedback on experiences of patients in vulnerable groups (e.g., either by stratifying data or by conducting data collection efforts focused on these groups.)</p> <p>5. The practice obtains feedback from patients through qualitative means (e.g. focus groups, individual interviews, patient walk through, suggestion boxes).</p> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> Report (Note: A suggestion box will not meet the intent of factors 1-4)</p>	
<p><b>6C: Quality Improvement</b></p> <p>The practice uses performance data to:</p> <ol style="list-style-type: none"> <li>1. Set goals and take action to improve quality on at least 3 measures based on 6A</li> <li>2. Set goals and take action to improve quality on at least 3 areas based on 6B</li> <li>3. Set goals and take action to improve care or service for vulnerable populations.</li> <li>4. Demonstrate improvement on at least two of the measures over time</li> <li>5. Involve patient/family in quality improvement teams or on practice advisory council</li> </ol> <p><b>Scoring:</b> Based on number of factors met</p> <p><b>Documentation:</b> NCQA's Quality Measurement and Improvement worksheet or equivalent report from the practice</p>	<p><b>Added</b></p> <ul style="list-style-type: none"> <li>• Action to improve or service for vulnerable populations</li> <li>• Practice evaluates performance over time</li> <li>• Patient/family involved in practice QI</li> </ul> <p>Consider linking evidence-based guidelines to performance measurement and quality improvement</p> <p>Note: Requirement to demonstrate improvement is only applicable for practices renewing Recognition; demonstrated performance through NCQA DRP, HSRP or BPRP also qualify</p>
<p><b>6D: Electronic Reporting Performance Measures</b></p> <p>The practice is transparent about its results on nationally approved performance measures:</p> <ol style="list-style-type: none"> <li>1. Results electronically transmitted to the public sector, health plan or others.</li> <li>2. Results are available to consumers/patients.</li> </ol> <p><b>Scoring:</b> Based on number of performance measures reported externally</p>	

<b>PCMH 2011 Elements and Standards</b>	<b>Summary of Changes and Explanation</b>
<i>Documentation:</i> Report or materials	

**RACE/ETHNICITY**

\* PCMH 2A: Basic Data, Factor 4, Race and Ethnicity

Race/Ethnicity Office of Management and Budget (OMB) Categories	
<u>Option #1: Two-question format (ethnicity before race)</u>	<u>Option #2: Combined format</u>
<p><b>Ethnicity</b></p> <ul style="list-style-type: none"> <li>• Hispanic or Latino</li> <li>• Not Hispanic or Latino</li> <li>• (Declined)</li> </ul> <p><b>Race (select one or more)</b></p> <ul style="list-style-type: none"> <li>• Black or African American</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• White</li> <li>• Asian</li> <li>• American Indian or Alaska Native</li> <li>• Some other race</li> <li>• (Declined)</li> </ul>	<p><b>Combined (check all that apply)</b></p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native</li> <li>• Asian</li> <li>• Black or African American</li> <li>• Hispanic or Latino</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• White</li> <li>• Other, please specify: _____</li> <li>• (Declined)</li> </ul>