

APPENDIX C

**CROSSWALK OF PPC-PCMH-CMS STANDARDS AND ELEMENTS TO
MEDICAL HOME CAPABILITIES BY TIER**

Table C.1. Crosswalk Between Tier Definitions (Table 2) and PPC-PCMH-CMS (Appendix B)

PPC-PCMH-CMS (Appendix B)	Description	Tier Definition (Table 2)
Standard 1: Access and Communication		
A. Has written standards for patient access and patient communication	TIER I: Implements processes to promote access and communication	4) The practice establishes written standards to support patient access, including policies for scheduling visits and responding to telephone calls and electronic communication (up to 9 specific factors).
B. Uses data to show it meets its standards for patient access and communication	TIER I: Measures implementation of access and communication processes	5) The practice collects data to demonstrate that it meets standards related to appointment scheduling and response times for telephone and electronic communication (up to 5 specific factors).
C. The practice discusses with patients and presents written information on the role of the medical home	TIER I: Obtains mutual agreement on role of Medical Home between physician and patient	1) The practice discusses with patients and presents written information on the role of the medical home that addresses up to 8 areas.
A. Has written standards for patient access and patient communication (Factor 1)	TIER I: Uses scheduling process to promote continuity with clinician	2) The practice establishes written standards on scheduling each patient with a personal clinician for continuity of care and the practice collects data to show that it meets its standards on continuity.
B. Uses data to show it meets its standards for patient access and communication (Factor 1)		
Standard 2: Patient Tracking and Registry Functions		
A. Uses data system for basic patient information (mostly non-clinical data)	TIER I: Uses data to identify and track medical home patients	3) The practice uses an electronic data system that includes searchable data such as patient demographics, visit dates and diagnoses (up to 12 specific factors), and the practice uses an electronic or paper-based system to identify clinically important conditions or risk factors among its patient population.
E. Uses data to identify important diagnoses and conditions in practice		

Table C.1 (continued)

PPC-PCMH-CMS (Appendix B)	Description	Tier Definition (Table 2)
B. Has clinical data system with clinical data in searchable data fields	TIER II (required): Uses data to identify and track medical home patients via an EMR	3) (Tier II) The practice uses an electronic data system that includes searchable data such as patient demographics, visit dates and diagnoses (up to 12 specific factors), and the practice uses an electronic or paper-based system to identify clinically important conditions or risk factors among its patient population, and the practice has an electronic health record, certified by the Certification Commission on Health Information Technology (C-CHIT), that captures searchable data on clinical information such as blood pressure, lab results or status of preventive services (up to 9 specific areas).
D. Uses paper or electronic-based charting tools to organize clinical information	TIER I: Organizes clinical data for individual patients (problem lists, medication lists, risk factors, structured progress notes)	7) The practice uses electronic or paper-based tools including medication lists and other tools such as problem lists, or structured templates for notes or preventive services to organize and document clinical information in the medical record.
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	TIER II (optional): Uses searchable electronic data to generate lists of patients and remind patients and clinicians of services needed	26) The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, such as patients needing clinician review or action or reminders for preventive care, specific tests or follow-up visits (up to 5 specific factors).
G. The practice conducts a comprehensive health assessment for all new patients to understand their risks and needs	TIER I: Uses health assessment tool to characterize patient needs and risks	8) The practice conducts a comprehensive health assessment for all new patients to understand their risks and needs including past medical history, risk factors and preferences for advance care planning (up to 5 specific factors).

Table C.1 Crosswalk Between Tier Definitions and PPC-PCMH-CMS

Table C.1 (continued)

PPC-PCMH-CMS (Appendix B)	Description	Tier Definition (Table 2)
Standard 3: Care Management		
A. Adopts and implements evidence-based guidelines for three conditions	TIER I: Adopts evidence-based clinical practice guidelines on preventive and chronic care	11) The practice identifies appropriate evidence-based guidelines that are used as the basis of care for clinically important conditions.
B. Generates reminders about preventive services for clinicians	TIER II (optional): Implements system to generate reminders (papers based or electronic) about preventive services at the point of care	27) The practice uses a paper-based or electronic system for reminders at the point of care based on guidelines for preventive services such as screening tests, immunizations, risk assessments and counseling.
C. Uses non-physician staff to manage patient care	TIER I: Organizes and trains staff in roles for care management (incl. staff feedback)	6) The practice defines roles for physician and nonphysician staff and trains staff, with nonphysician staff involved in reminding patients of appointments, executing standing orders or educating patients/families.
D. Conducts care management, including care plans, assessing progress, addressing barriers	<p>TIER I: Uses integrated care plan to plan and guide patient care</p> <p>TIER I: Provides pre-visit planning and after-visit follow-up for medical home patients</p> <p>TIER I: Reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements</p>	<p>9) For three clinically important conditions, the physician and nonphysician staff conduct care management using an integrated care plan to set goals, assess progress and address barriers.</p> <p>10) For three clinically important conditions, the physician and nonphysician staff conduct care management planning ahead of the visit to make sure that information is available and the staff is prepared as well as following up after the visit to make sure that the treatment plan (including medications, tests, referrals) is implemented.</p> <p>17) The practice reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements.</p>

Table C.1 Crosswalk Between Tier Definitions and PPC-PCMH-CMS

Table C.1 (continued)

PPC-PCMH-CMS (Appendix B)	Description	Tier Definition (Table 2)
D. Conducts care management, including care plans, assessing progress, addressing barriers (Factor 2)	TIER II (optional) : Implements system to generate reminders (paper based or electronic) about chronic care needs at the point of care	28) The practice uses a paper-based or electronic system for reminders at the point of care based on guidelines for chronic care needs
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	TIER II (required) : Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities TIER II (required) : Uses medication reconciliation post discharge to avoid interactions or duplications	18) The practice on its own or in conjunction with an external organization has a systematic approach for identifying and coordinating care for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care (up to 6 specific factors). 19) The practices reviews post-hospitalization medication lists and reconciles with other medications.
Standard 4: Patient Self-Management Support		
A. Assesses language preference and other communication barriers	TIER I: Documents patient self-management plan (including end-of-life planning, home monitoring)	12)The practice supports patient/family self-management through activities such as systematically assessing patient/family-specific communication barriers and preferences, providing self-monitoring tools or personal health record, and providing a written care plan
B. Actively supports patient self-management	TIER I: Provides patient education and support TIER I: Encourages family involvement	13) The practice supports patient/family self-management through providing educational resources, and providing/connecting families to self-management resources 14) The practice encourages family involvement in all aspects of patient self-management.

Table C.1 (continued)

PPC-PCMH-CMS (Appendix B)	Description	Tier Definition (Table 2)
Standard 5: Electronic Prescribing		
<p>A. Uses electronic system to write prescriptions</p> <p>B. Has electronic prescription writer with safety checks</p> <p>C. Has electronic prescription writer with cost checks</p>	<p>TIER II (optional): Uses electronic prescribing tools to reduce medication errors, promote use of generics, and assist in medication management</p>	<p>20) The practice uses an electronic system to write prescriptions which can print or send prescriptions electronically, clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, which includes safety alerts that may be generic or specific to the patient (up to 8 specific factors), and clinicians engage in cost-efficient prescribing by using a prescription writer that has general automatic alerts for generic or is connected to a payer-specific formulary.</p>
Standard 6: Test Tracking		
<p>A. Tracks tests and identifies abnormal results systematically</p>	<p>TIER I: Tracks tests and provides follow-up</p>	<p>15) The practice systematically tracks tests and follows up using steps such as making sure that results are available to the clinician, flagging abnormal test results, and following up with patients/families on all abnormal test results (up to 4 specific factors).</p>
Standard 7: Referral Tracking and Coordination		
<p>A. Tracks referrals using paper-based or electronic system</p>	<p>TIER I: Tracks referrals including referral plan and patient report on self referrals</p>	<p>16) The practice coordinates referrals designated as critical through steps such as providing the patient and consultant/specialist practitioner with the reason for the consultation and pertinent clinical findings, tracking the status of the referral, obtaining a report back from the practitioner, and asking patients about self-referrals and obtaining reports from the practitioner(s).</p>

Table C.1 Crosswalk Between Tier Definitions and PPC-PCMH-CMS

Table C.1 (continued)

PPC-PCMH-CMS (Appendix B)	Description	Tier Definition (Table 2)
Standard 8: Performance Reporting and Improvement		
A. Measures clinical and/or service performance by physician or across the practice (must pass)	TIER II (optional): Measures performance on clinical quality and patient experiences	23) The practice measures or receives data on performance such as clinical process, clinical outcomes, service data or patient safety issues, and the practice collects data on patient experience with care, addressing up to 3 areas.
B. Survey of patients' care experience		
C. Reports performance across the practice or by physician	TIER II (optional): Reports to physicians on performance	24) The practice reports performance data to physicians.
D. Sets goals and takes action to improve performance	TIER II (optional): Uses data to set goals and take action to improve performance	25) The practice uses performance data to set goals and take action where identified to improve performance.
Standard 9: Advanced Electronic Communications		
A. The practice provides patients/families with access to an interactive Web site	TIER II (optional): Use of secure electronic communication between the patient and the healthcare team TIER II (optional): Use of secure systems that provide for patient access to personal health information	21) The practice provides patients/families with access to an interactive Web site that allows electronic communication. 22) The practice provides for patient access to personal health information such as test results or prescription refills or to see elements of their medical record and import elements of their medical record into a personal health record.

Table C.1 Crosswalk Between Tier Definitions and PPC-PCMH-CMS

APPENDIX D

PPC-PCMH-CMS SCORING WORKSHEET

Practices may use this worksheet to determine the medical home tier for which they expect to qualify. The table below lists elements required to qualify for that tier. Practices should mark the checkboxes next to each element they meet with a 50 percent score or higher, as indicated in the PPC[®]-PCMH[™] CMS Version. Practices qualify for Tier 1 if they pass the 14 required PPC[®]-PCMH[™] CMS elements shown below. These 14 elements correspond to the 17 capabilities in Table 2. Practices qualify for Tier 2 if they meet the requirements for Tier 1, pass the 2 additional required elements shown, and pass three of the 11 additional elements (as shown below). If all of the elements under a specific tier are checked, the practice qualifies for that tier.

<i>Required Elements</i>	<i>Description</i>		
Tier 1			
1	PPC-PCMH Standard 1, Element A with Factors 1, 3, 4, 5, 6, and 8.	Access and Communications Processes	<input type="checkbox"/>
2	PPC-PCMH Standard 1, Element B with Factor 1	Access and Communication Results	<input type="checkbox"/>
3	PPC-PCMH Standard 1, Element C	Giving Patient Information on Role of Medical Home	<input type="checkbox"/>
4	PPC-PCMH Standard 2, Element A	Basic System for Managing Patient Data	<input type="checkbox"/>
5	PPC-PCMH Standard 2, Element D with Factors 2 and 3	Organizing Clinical Data (includes lists of over-the-counter and prescribed medications)	<input type="checkbox"/>
6	PPC-PCMH Standard 2, Element E	Identifying Important Conditions	<input type="checkbox"/>
7	PPC-PCMH Standard 2, Element G	Comprehensive Health Assessment	<input type="checkbox"/>
8	PPC-PCMH Standard 3, Element A	Guidelines for Important Conditions	<input type="checkbox"/>
9	PPC-PCMH Standard 3, Element C with Factors 1 and 2	Practice Organization	<input type="checkbox"/>
10	PPC-PCMH Standard 3, Element D with Factors 1, 3, 6, and 12	Care Management for Important Conditions (includes individualized care plans, reviewing medications, pre-visit planning and after-visit follow-up)	<input type="checkbox"/>
11	PPC-PCMH Standard 4, Element A	Documenting Communication Needs	<input type="checkbox"/>
12	PPC-PCMH Standard 4, Element B with Factor 7	Self-Management Support (includes written plan to patient/family)	<input type="checkbox"/>
13	PPC-PCMH Standard 6, Element A	Test Tracking and Follow-Up	<input type="checkbox"/>
14	PPC-PCMH Standard 7, Element A	Referral Tracking and Coordination	<input type="checkbox"/>
Tier 2			
		Meets Tier 1 Requirements	<input type="checkbox"/>
15	PPC-PCMH Standard 2, Element B	Electronic System for Clinical Data	<input type="checkbox"/>
16	PPC-PCMH Standard 3, Element E with Factor 11	Continuity of Care (includes review of post-hospitalization medication lists)	<input type="checkbox"/>
	Optional Elements	(Must pass 3)	
17	PPC-PCMH Standard 2, Element F	Use of System for Population Management	<input type="checkbox"/>
18	PPC-PCMH Standard 3,	Preventive Service Clinician Reminders	<input type="checkbox"/>

D.4

	Required Elements	Description	
	Element B		
19	PPC-PCMH Standard 3, Element D with Factors 1, 2, 3, 6, and 12	Care Management for Important Conditions (includes individualized care plans, guideline-based reminders, reviewing medications, pre-visit planning and after-visit follow-up)	<input type="checkbox"/>
20	PPC-PCMH Standard 5, Element A	Electronic Prescription Writing	<input type="checkbox"/>
21	PPC-PCMH Standard 5, Element B	Prescription Decision Support—Safety	<input type="checkbox"/>
22	PPC-PCMH Standard 5, Element C	Prescription Decision Support—Efficiency	<input type="checkbox"/>
23	PPC-PCMH Standard 8, Element A	Measures of Performance	<input type="checkbox"/>
24	PPC-PCMH Standard 8, Element B	Patient Experience Data	<input type="checkbox"/>
25	PPC-PCMH Standard 8, Element C	Reporting to Physicians	<input type="checkbox"/>
26	PPC-PCMH Standard 8, Element D	Setting Goals and Taking Action	<input type="checkbox"/>
27	PPC-PCMH Standard 9, Element A	Availability of Interactive Web Site	<input type="checkbox"/>