



**Standards and Guidelines for  
Physician Practice Connections<sup>®</sup> —  
Patient-Centered Medical Home  
(PPC-PCMH<sup>™</sup>)  
CMS Version**

**October 6, 2008**

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## Template for Standards and Elements

**PPC-PCMH CMS Version**

**25 capabilities**

### Standard PPC X: Title

*Standards are authoritative statements about acceptable performance or results. Each standard includes a statement of an attribute or expectation.*

- Each standard has a number using the three-letter identifier and consecutive numbers (e.g., PPC 1, PPC 2), as well as a title.

#### Intent

*The Intent is a brief statement explaining the purpose of the standard.*

#### Element 1A: Title

#### Scoring Tier

*There is at least one element for each standard. An element describes a specific component of performance that is individually evaluated and scored.*

- Each element has a designated number of points; element points sum to the standard points.
- Elements are alphabetically lettered within a standard (e.g., PPC 4A).
- Elements are assigned to a tier.
- Factors are subcomponents of the performance measured by an element and are used for scoring.
- Some factors are required for a specific tier.
- Factors are numbered. Not all elements have factors.
- Where an element includes multiple numbered factors, the scoring (below) indicates the number of factors that the practice must meet to achieve each scoring level.

#### Scoring

	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	Performance level needed	Performance level needed	Performance level needed	Performance level needed	Performance level

Each element has designated element points, or total possible points. The scoring indicates what the practice needs to do to achieve each of the five scoring levels for an element, and under what circumstances the element is not applicable to the practice.

For CMS demonstration purposes, practices must achieve a 50% or higher score on required elements. If there is no 50% scoring option, the practice must achieve the next higher scoring option.

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**Data source** **Data sources** are types of documentation that practices need to submit to demonstrate performance related to specific elements. The list of data sources within each element is not prescriptive nor does it exclude other potential sources. The practice may have acceptable alternative methods that demonstrate performance.

Data sources *must* document that the practice has the required processes in place, not those it plans to implement in the future. There are four basic types of data sources practices can use to demonstrate performance.

1. **Documented process**—Written statements describing the practice’s procedures. The statements may include protocols or other documents that describe actual processes or forms the practice uses in work flow such as referral forms, checklists and flow sheets. Forms should not be blank but instead should include blinded information that demonstrates how the practice uses it.
2. **Reports**—Aggregate data showing evidence of action, including manual and computerized reports the practice produces to manage its operations, such as a list of patients who are due for a visit or test.
3. **Records or files**—Actual patient files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element. There are two ways to measure this performance: a) a query of electronic files yielding a count or; b) the sample selection process provided.
4. **Materials**—Prepared material the practice provides to patients or clinicians including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.

**Scope of review** Most element are scored once for the practice. However, elements associated with clinically important conditions identified by the practice are scored three times and averaged, once for each clinically important condition.

**Explanation** The explanation provides additional information to the practice, such as for the intent of the element, how the element relates to other elements, terms used and the evaluation process.

**Examples** Examples show one or more ways to meet the requirements of the element.  
**Exception** Exceptions from the element are listed here. There are two types of exceptions: situations in which a factor or element is not applicable (NA); actions or types of evidence that might appear to meet the standard, but do not.

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**Physician Practice Connections—  
Patient-Centered Medical Home  
(PPC-PCMH) Standards  
CMS Version**

## PPC 1: Access and Communication

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

### Intent

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

### Element A: Access and Communication Processes

Tier I (required)

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

### Scoring

100%	75%	50%	25%	0%
Practice has written process for 9-12 items (must include Factors 1,3,4,5,6, & 8)	Practice has written process for 7-8 items (must include Factors 1,3,4,5,6, & 8)	No scoring option	Practice has written process for 2-6 items	Practice has written process for 0-1 items

**Data source** Documented process, Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation**      **IT required:** Basic  
**Condition-specific:** No  
**Details:** The practice should have standards for staff to respond to requests during office hours as well as to urgent concerns after hours. The following points apply to particular items.

- *Item 1*—If the practice does not assign patients to a personal physician, the practice may use their written policy for scheduling patients with a requested physician.
- *Item 2*—The goal is to minimize trips for the patient and as much as possible provide one-stop shopping.
- *Item 7*—Staff return patient calls within a time frame specified by the practice's policies.
- *Item 8*—A phone message that only directs patients to the emergency room after hours does not meet the standard.
- *Items 9 and 10*—Some practices use secure e-mail or an interactive Web site, either attached to the practice or from an external organization, for making appointments, communicating test results, renewing prescriptions or other nonurgent needs.
- *Item 11*—Where applicable, practices should utilize bilingual staff or interpretation services. The practice does not need a written policy or data to demonstrate that it makes language services available. If a practice has bilingual staff, it does not need a written policy or data to demonstrate that it makes language services available. The practice may write a note in the Support Test/Notes box in the Survey Tool stating the percent of patients needing language services and the languages the staff speak. Practices must demonstrate that language services offered address the patient population's needs.

**Examples**      **Data source:** Written procedures for staff for appointments, triage and patient communication; log or schedule to demonstrate capacity (Item 3).

Element B: Access and Communication Results		Tier I (required)		
		Yes	No	NA
<b>The practice's data shows that it meets access and communication standards in 1A:</b>				
1.	<b>Visits with assigned personal clinician for each patient</b>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	<b>Appointments scheduled to meet the standards in Items 2-6 in 1A</b>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	<b>Response times to meet standards for timely response to telephone requests</b>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	<b>Response times to meet its standards for timely response to e-mail and interactive Web requests</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<b>Language services for patients with limited English proficiency.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scoring	100%	75%	50%	25%	0%
		Practice's data meets 5 items (must include Factor 1)	Practice's data meets 4 items (must include Factor 1)	Practice's data meets 3 items (must include Factor 1)	Practice's data meets 2 items

<b>Data source</b>	Reports
<b>Scope of review</b>	ONCE— This element is scored once for the organization.
<b>Explanation</b>	<p><b>IT required:</b> Basic—Intermediate</p> <p><b>Condition-specific:</b> No</p> <p><b>Details:</b> The tracking reports should show that the practice meets its own standards for access through appointments, telephone calls and e-mail or interactive Web site where applicable.</p> <p>The practice can do spot checks for these items, such as monitoring appointment wait times and telephone response times for a week to determine how well it meets standards.</p> <p>Practices may provide patient experience survey results, if the questions are specific to the access and communication factors.</p> <p>For Factor 3, practices must address both Factors 7 and 8 from Element A. “Timely” refers to the standards practices set for Factors 7 and 8 in Element A.</p> <p>For Item 4, the practice may exclude patients who do not have e-mail.</p> <p>The practice may respond “not applicable” (NA) to Item 5 if its patient population does not require language services.</p>
<b>Examples</b>	<p><b>Data source:</b> Tracking reports, either paper or screen shots, showing records for a period of appointments with personal clinicians, average wait for appointments, average time for returning telephone calls and e-mails.</p>

<b>Element C: Giving Patient Information on Role of Medical Home</b>	<b>Tier I (required)</b>		
	Yes	No	NA
<b>The practice discusses with patients and presents written information on the role of the medical home, including the following:</b>			
1. That the patient’s personal physician explains to the patient that the practice is concerned about the entire range of a patient’s health and will pay attention to all health care needs	<input type="checkbox"/>	<input type="checkbox"/>	
2. That the practice will provide the patient with information about when and where to seek care at other places	<input type="checkbox"/>	<input type="checkbox"/>	
3. That the practice will provide information on office hours and how to make appointments	<input type="checkbox"/>	<input type="checkbox"/>	
4. That the practice will provide information about how to communicate outside of visits	<input type="checkbox"/>	<input type="checkbox"/>	
5. That the practice will help arrange and coordinate needed care	<input type="checkbox"/>	<input type="checkbox"/>	
6. That the practice encourages patients to use the practice for new issues and ongoing issues	<input type="checkbox"/>	<input type="checkbox"/>	
7. That the practice encourages patients to give information on all care obtained outside of the practice, including visits to other specialists, hospitalizations, ED visits or visits to other types of healthcare providers	<input type="checkbox"/>	<input type="checkbox"/>	
8. That the practice encourages patients to inform the practice about all medications used	<input type="checkbox"/>	<input type="checkbox"/>	
9. That the practice encourages patient self-management	<input type="checkbox"/>	<input type="checkbox"/>	

	100%	75%	50%	25%	0%
<b>Scoring</b>	Practice meets 9 items	No scoring option	No scoring option	No scoring option	Practice meets <9 items

**Data source** Materials  
**Scope of review** ONCE— This element is scored once for the organization.

**Explanation** **IT required:** Basic  
**Condition-specific:** No  
**Details:** For medical homes to function as such there must be a common understanding between the patient and the practice about what it means for the practice to function as a medical home. Patients must understand what the medical home will do for them and what their responsibilities are to the medical home.

**Examples** Patient brochure  
 Statement of patient rights and responsibilities

## PPC 2: Patient Tracking and Registry Functions

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

### Intent

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

### Element A: Basic System for Managing Patient Data

Tier I (required)

The practice uses an electronic data system for patients that includes the following searchable patient information:

	Yes	No	NA
1. Name	<input type="checkbox"/>	<input type="checkbox"/>	
2. Date of birth	<input type="checkbox"/>	<input type="checkbox"/>	
3. Gender	<input type="checkbox"/>	<input type="checkbox"/>	
4. Marital status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Language preference	<input type="checkbox"/>	<input type="checkbox"/>	
6. Voluntarily self-identified race/ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	
7. Address	<input type="checkbox"/>	<input type="checkbox"/>	
8. Telephone (primary contact number)	<input type="checkbox"/>	<input type="checkbox"/>	
9. E-mail address (or "none" for patients)	<input type="checkbox"/>	<input type="checkbox"/>	
10. Internal ID	<input type="checkbox"/>	<input type="checkbox"/>	
11. External ID	<input type="checkbox"/>	<input type="checkbox"/>	
12. Emergency contact information	<input type="checkbox"/>	<input type="checkbox"/>	
13. Current and past diagnoses	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dates of previous clinical visits	<input type="checkbox"/>	<input type="checkbox"/>	
15. Billing codes for services	<input type="checkbox"/>	<input type="checkbox"/>	
16. Legal guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Health insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>	
18. Patient/family preferred method of communication.	<input type="checkbox"/>	<input type="checkbox"/>	

### Scoring

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

**Data source** Reports

**Scope of review** ONCE— This element is scored once for the organization.

**Explanation**      **IT required:** Basic  
**Condition-specific:** No  
**Details:** A practice management system or registry may enable the practice to meet this element; an EHR or more sophisticated system should include this basic data also.

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

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

*Item 9*—The item evaluates the capacity of the electronic system of the practice to collect e-mail addresses from its patients; it does not depend on whether or not a given patient has an e-mail address.

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

*Item 10*—The Internal ID is the primary identifier established and used by the practice to identify patients.

*Item 11*—The external ID is an identification number by which a patient is identified in a data base that is external to the practice (i.e., an identification number from a hospital, facility or provider that is outside of the practice). This can be the patient’s Medicare HIC number.

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

Element B: Electronic System for Clinical Data		Tier II (required)		
		Yes	No	NA
The practice has an electronic health record, certified by the Certification Commission for Healthcare Information Technology (CCHIT), that captures the following clinical patient information in searchable data fields:				
1.	Status of age-appropriate preventive services (immunizations, screenings, counseling)	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Allergies and adverse reactions	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Height	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Weight	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Body mass index (BMI) calculated	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Laboratory test results	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Presence of imaging results	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Presence of pathology reports	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Presence of advance directives.	<input type="checkbox"/>	<input type="checkbox"/>	

Scoring	100%	75%	50%	25%	0%
		System has 9-10 data fields	System has 7-8 data fields	System has 5-6 data fields	System has 3-4 data fields

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Intermediate

**Source of content:** IOM EHR Letter Report

**Condition-specific:** No

**Details:** For this element, the practice uses a CCHIT-certified electronic health record. This can be any CCHIT-certified product regardless of when the certification occurred. All items should be kept in coded form; for Items 8–10, data may indicate the presence of a written report not in the system.

A practice may have paper reports documenting the following items:

- imaging results
- pathology results
- advance directives

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

**[Note: This version includes no “Element C” to maintain lettering consistency with other related NCQA versions.]**

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**Element D: Organizing Clinical Data**

**Tier I (required)**

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

1. Problem lists
2. Lists of over-the-counter medications, supplements and alternative therapies
3. Lists of prescribed medications including both chronic and short-term
4. Structured template for age-appropriate risk factors (at least 3)
5. Structured templates for narrative progress notes

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

Scoring	100%	75%	50%	25%	0%
	75-100% of records of patients seen in the past 3 months include Factors 2 and 3 and at least 1 other with information documented	50-74% of records of patients seen in the past 3 months include Factors 2 and 3 and at least 1 other with information documented	25-49% of records of patients seen in the past 3 months include Factors 2 and 3 and at least 1 other with information documented	10-24% records of patients seen in the past 3 months include at least 3 tools with information documented	Less than 10% of patient records include

**Data source** Records or files

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic

**Source of content:** IOM EHR Letter Report

**Condition-specific:** No

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

*Item 4*, age-appropriate risk factor assessments, should come from evidence-based guidelines. Age-appropriate risk factors may include, but are not limited to the following examples:

- Use of tobacco for age 12 and over
- Cognitive assessment for new patients over 75
- Use of alcohol for age 15 and over
- Risk of falls for the elderly

- Secondhand smoke
- Use of seat belts
- Use of bike helmets
- Mental health concerns
- Obesity
- At-risk sexual behavior
- Violence
- Family history of cancer or diabetes.

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

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

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

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

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

**Method 2—Review a sample of medical records.**

1. Use the three important diagnoses and conditions identified. To determine important conditions, the practice analyzes its entire population. Clinically important conditions are chronic or recurring conditions that the practice sees. (Refer to Element 2E for further explanation of identifying clinically important conditions.)
2. Choose the weekday nearest the date one month prior to today.
3. Going either backward or forward from that date, select the first 36 patients who had a nonacute care visit and who have any one or more of the three chosen clinically important conditions. You will review these same 36 patient files for several elements.

Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see Element 2E).

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- Denominator = The sample of patient medical records using sampling method
- Numerator = The patients from the medical record review for whom three tools are completed.

To receive credit the practice must show the percentage of patients seen in the past three months for whom the practice has documented information in the charting tools.

**Examples**

**Data source:** Medical record review.

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

Element E: Identifying Important Conditions		Tier I (required)	
The practice uses an electronic or paper-based system to identify the following diagnoses and conditions:		Yes	No
1.	Practice’s most frequently seen diagnoses	<input type="checkbox"/>	<input type="checkbox"/>
2.	Most important risk factors in the practice’s patient population	<input type="checkbox"/>	<input type="checkbox"/>
3.	Three conditions that are clinically important in the practice’s patient population.	<input type="checkbox"/>	<input type="checkbox"/>

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic  
**Condition-specific:** No  
**Details:** This element requires the practice to use data for population management, producing reports on most frequently seen conditions and risk factors, and determining three conditions on which it concentrates care management.  
 The most **frequently seen diagnoses** are those that the practice sees most often and may include single episode conditions, such as colds or urinary tract infections, or chronic conditions. The practice can use any of the following criteria to identify the most frequently seen diagnoses, the most important risk factors and the three important conditions:

- Number of patients with the conditions, problems or risk factors
- Number of visits for the conditions or problems
- Total fees billed or other measures of cost associated with the conditions or problems, or risk factors.

To identify the most **important risk factors** in the practice’s population, the practice uses community-based demographic characteristics of its patients and identifies the risks generally associated with these demographic characteristics (e.g. poverty). Alternatively the practice may analyze the presence or absence of those risk factors in

its own patient population.

To determine the **clinically important conditions**, the practice analyzes its entire population. In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions. The clinically important conditions are chronic or recurring conditions that the practice sees such as otitis media, asthma, diabetes or congestive heart failure. In some cases, the most frequently seen conditions may be the same as the clinically important conditions. In addition, the practice can also use the following criteria to identify the three important conditions:

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

**Examples**      **Data source:** Reports

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

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

**Data source**      Reports

**Scope of review**      ONCE—This element is scored once for the organization.

**Explanation**      **IT required:** Intermediate

**Condition-specific:** No

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

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

Some examples of the population management function are these or similar items.

- Identify all patients who are taking a medication for which the practice received a warning.
- Identify all patients with ischemic vascular disease not taking appropriate medication.
- Identify all women over 50 who are due for a mammogram
- Identify all adult patients with elevated LDL for whom appropriate medication has not been prescribed
- Identify all diabetic patients whose HbA1c >9
- Identify all patients with blood pressure >140/90

The practice’s system needs to link the decision rules to the relevant patient-specific data, such as demographics, age, ICD Diagnosis codes, CPT<sup>1</sup> Procedure codes, test results, medication and clinical data (e.g., blood pressure, weight or BMI, smoking status).

If the system has the capability to generate lists but has not used it, the practice may receive an override score of 25%.

**Examples**

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

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

Element G: Comprehensive Health Assessment		Tier I (required)			
<p>The practice conducts a comprehensive health assessment for all patients to understand their risks and needs and annually updates information that includes the following:</p> <ol style="list-style-type: none"> <li>1. Demographics and family characteristics</li> <li>2. Patient medical history</li> <li>3. Patient behavioral risks</li> <li>4. Status of age-appropriate preventive services</li> <li>5. Allergies and adverse reactions</li> <li>6. Advance care plans</li> </ol>		<p>Yes</p>	<p>No</p>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	Practice collects 6 items	No scoring option	Practice collects 5 items	Practice collects 1-4 items	Practice does not collect any items

**Data source** Documented process, materials

**Scope of review** ONCE— This element is scored once for the organization.

**Explanation** **IT required:** Basic  
**Condition-specific:** No  
**Details:** All of this information is important to understanding the whole patient. The most appropriate time to collect this information is when the patient is first seen by the practice.

**Examples**

- Forms used to collect information from new patients

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## PPC 3: Care Management

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

### Intent

The practice identifies appropriate evidence-based guidelines and applies them, as appropriate, to the identified needs of individual patients over time and with the intensity needed by the patients.

### Element A: Guidelines for Important Conditions

### Tier I (required)

The practice adopts and implements evidence-based diagnosis and treatment guidelines for:

Yes No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. First clinically important condition  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Second clinically important condition | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Third clinically important condition. | <input type="checkbox"/> | <input type="checkbox"/> |

### Scoring

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

**Data source** Materials

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic

**Condition-specific:** Yes

**Details:** The physicians in the practice adopt evidence-based guidelines and use them. The practice's guidelines must cover three clinically important conditions for its population. The practice's workflow organizers ensure that the guidelines are meaningful to the clinicians in the practice and that they are consistent with the standards of care that the practice wants to follow.

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

Practices will use the same three clinically important conditions for Elements 2D, 2E, 3A, 3D, 4B and 9C.

When identifying the "first clinically important condition," the "second clinically important condition" and the "third clinically important condition," practices are not indicating any kind of hierarchy among the three.

See PPC 2E (explanation) for additional information on selecting clinically important conditions.

- Examples**      **Data source:** Workflow organizers, which demonstrate both adoption and implementation of guidelines by the practice.
- Paper-based organizers—algorithms for developing treatment plans, flow sheets or templates for documenting progress.
  - Electronic system organizers (registry, EHR or other system)—screenshots showing templates for treatment plans and documenting progress.

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

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

**Data source**      Reports

**Scope of review**      ONCE—This element is scored once for the organization.

**Explanation**      **IT required:** Basic if paper-based system, intermediate if electronic system

**Condition-specific:** No

**Details:** This element requires using alerts and reminders across the practice for patients who need particular services. The practice identifies patients by age, gender and status of preventive services, and prompts the clinician at the point of care. The following are examples of types of alerts and reminders:

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

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

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

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

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

**Element C: Practice Organization** **Tier I (required)**

<b>The care team manages patient care in the following ways:</b>	<b>Yes</b>	<b>No</b>
1. <b>Defining roles for physician and nonphysician staff</b>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Training staff for their roles</b>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Nonphysician staff remind patients of appointments and collect information prior to appointments</b>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Nonphysician staff execute standing orders for medication refills, order tests and deliver routine preventive services</b>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Nonphysician staff educate patients/families about managing conditions</b>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Scoring</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
	Practice does 5 items	Practice does 4 items, including Factors 1 and 2	Practice does 3 items, including Factors 1 and 2	No scoring option	Practice does 0-1 items

**Data source** Documented process

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic  
**Condition-specific:** No  
**Details:** While physicians are responsible for directing and coordinating patient care, managing patient care is usually a team effort that involves all members of the practice who interact with patients (i.e., physicians, nurses, allied health personnel/care coordinator/family partner). The practice uses a team approach in managing patient care. Shared responsibilities are designed to maximize use of each team member’s level of training and expertise. In small practices, this may be designated roles for the physician, the nurse and the administrative person if there is one. In most practices, the availability of nurse case managers will only be through the patients’ health plans or other large organization. In some practices physicians may handle significant patient care responsibilities, especially for complex patients. Disease management or care management may be provided internally by the practice or group or available to the patient externally, usually through the health plan.  
*Item 2*—Standing orders can be physician pre-approved, or executed without physician prior approval, depending upon staff licensure, training or level of expertise. Examples of standing orders include standing test protocols, standing medication orders, and any standing order that nonphysician staff will carry out.

**Examples** **Data source:** Job descriptions, protocols, written standing orders.

**Element D: Care Management for Important Conditions****Tier I (required)**

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

1. Conducting pre-visit planning
2. Using guideline-based reminders (paper-based or electronic) at the point of care  
*For Tier II, Factor 2 must be met.*
3. Writing individualized care plans with a whole person orientation
4. Writing individualized treatment goals
5. Assessing patient progress toward goals
6. Reviewing lists of medications (including prescribed medications, over the counter medications, and herbals/supplements) with patients to avoid interactions and duplications
7. Reviewing self-monitoring results and incorporating them into the medical record at each visit
8. Assessing barriers when patients have not met treatment goals
9. Assessing barriers when patients have not filled, refilled or taken prescribed medications
10. Following up when patients have not kept important appointments
11. Reviewing longitudinal representation of patient's historical or targeted clinical measurements
12. Completing after-visit follow-up
13. Engaging in advance care planning with the patient.

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

Scoring	100%	75%	50%	25%	0%
	75% or more of patients seen in the past 3 months have at least 6 items documented, including Factors 1, 3, 6, & 12 (for Tier II must also include Factor 2)	50-74% of patients seen in the past 3 months have at least 6 items documented, including Factors 1,3, 6, & 12 (for Tier II must also include Factor 2)	25-49% of patients seen in the past 3 months have at least 6 items documented, including Factors 1,3, 6, & 12 (for Tier II must also include Factor 2)	11-24% of patients seen in the past 3 months have at least 6 items documented	10% or fewer patients seen in the past 3 months have at least 6 items documented

**Data source** Records or files

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** IT required: Basic  
Source of content: IOM

**Condition-specific:** Yes

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

Though the starting point for this element is patients with one of three clinically important conditions, care plans and individualized treatment goals take into account that many of these patients have co-morbid conditions. Care plans and treatment goals reflect the need to consider the whole patient.

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

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

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

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

**Method 2—Review a sample of medical records.**

1. Use the three important diagnoses and conditions identified. To determine important conditions, the practice analyzes its entire population. Clinically important conditions are chronic or recurring conditions that the practice sees. (Refer to Element 2E for further explanation of identifying clinically important conditions.)
2. Choose the weekday nearest the date one month prior to today.
3. Going either backward or forward from that date, select the first 36 patients who had a nonacute care visit and who have any one or more of the three chosen clinically important conditions. You will review these same 36 patient files for several elements.

Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see Element 2E).

- Denominator = The sample of patient medical records
- Numerator = The patients from the medical record review for whom at least four items are entered.

*Item 2*—Alerts and reminders prompt the clinician at the point of care about services that may be needed based on evidence-based guidelines. The alerts and reminders can be paper-based or electronic. Examples include reminders for annual eye exams for patients with diabetes.

*Item 3*—Written care plans address the respective responsibilities of the medical home and specialists to whom the practice has referred the patient.

*Items 8–10*—Barriers to be addressed may include the patients' lack of understanding, motivation, financial need, insurance issues or transportation problems.

*Item 10*—Important appointments are those that the practice has requested the patient to make in order to follow standards of care (e.g., follow-up visits for monitoring blood pressure or blood sugar levels). Examples of after-visit follow up (Item 11) may include checking with patients to confirm they filled a prescription or received care with a consultant.

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

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

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

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**Element E: Continuity of Care** **Tier II (required)**

	Yes	No
The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care:		
1. Identifies patients who receive care in facilities	<input type="checkbox"/>	<input type="checkbox"/>
2. Systematically sends clinical information to the facilities with patients as soon as possible	<input type="checkbox"/>	<input type="checkbox"/>
3. Reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes	<input type="checkbox"/>	<input type="checkbox"/>
4. Contacts patients after discharge from facilities within 30 days	<input type="checkbox"/>	<input type="checkbox"/>
5. Provides or coordinates follow-up care to patients/families who have been discharged	<input type="checkbox"/>	<input type="checkbox"/>
6. Coordinates care with external disease management or case management organizations, as appropriate	<input type="checkbox"/>	<input type="checkbox"/>
7. Communicates with patients/families receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input type="checkbox"/>
8. Communicates with case managers for patients receiving ongoing disease management or high risk case management	<input type="checkbox"/>	<input type="checkbox"/>
9. For patients transitioning to other care, develops a written transition plan in collaboration with the patient and family	<input type="checkbox"/>	<input type="checkbox"/>
10. Aids in identifying a new primary care physician or specialists or consultants and offers ongoing consultation	<input type="checkbox"/>	<input type="checkbox"/>
11. Reviews post-hospitalization medication lists and reconciles with other medications.	<input type="checkbox"/>	<input type="checkbox"/>

	100%	75%	50%	25%	0%
<b>Scoring</b>	Activities include 6-11 items including Factor 11	Activities include 4-5 items including Factor 11)	No scoring option	Activities include 2 items	Activities include 0-1 items

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic  
**Condition-specific:** No  
**Details:** When the need for facility care is anticipated (i.e., when not an emergency), the practice provides the facility with appropriate information. The practice or external organization reviews data to identify patients who receive inpatient or outpatient care at a facility. A facility may be a hospital, an emergency room, a skilled nursing facility or a surgical center. The practice does not wait for these patients to make an appointment, but contacts them directly. Proactive contact includes assisting patients with appropriate care to prevent worsening of their conditions. The practice has a process in place to receive information on discharges from facilities. The practice is responsible for following up on discharges about which they are informed. After the

practice has contacted patients, it ensures they receive follow-up care as necessary. Examples of follow-up care include, but are not limited to, physician counseling, referrals to community resources, disease or case management or self-management support programs.

When a patient requires disease management or case management due to frequent emergency room visits, frequent hospitalizations, clinically important conditions or other reason, the practice maintains continuity of care by regularly communicating with both the patient and the case manager. The practice or external organization has a written protocol describing the schedule for communication and at least one example showing the frequency of communication between case manager and patient and one example of case manager and physician. Youth and family receive coordination and support to link their health and transition plans with other relevant adolescent and adult practitioners.

### **Examples**

**Data source:** May be from the practice itself or from an external case management organization such as a disease management organization with which the practice works. The data sources may include:

- Protocols that include the practice's timeframe for patient follow up after an admission or emergency room visit
- Protocols for using care plans and patient visit flow sheets
- Log of patients receiving care from different types of facilities
- Printout from registry, EHR, hospital emergency room, admitting department or other computerized reports that include a list of identified patients, emergency room visits and inpatient admissions
- Manual or electronic patient health/needs assessments
- Blinded case management or medical record notes.

## PPC 4: Patient Self-Management Support

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

### Intent

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

### Element A: Documenting Communication Needs

Tier I (required)

The practice assesses patient/family-specific barriers to communication using a systematic process to:

Yes No

1. Identify and display in the record the language preference of the patient and family

2. Assess both hearing and vision barriers to communication.

### Scoring

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

**Data source** Documented process, Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** IT required: Basic

**Condition-specific:** No

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

The practice should provide documentation that shows it identifies language preference using a paper-based or electronic systematic process that prompts the practice staff to get the information from the patient or family. Census bureau information to identify language preference does not meet the intent of this item.

### Examples

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

**Element B: Self-Management Support****Tier I (required)**

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

1. Assesses patient/family preferences, readiness to change and self-management abilities
2. Provides educational resources in the language or medium that the patient/family understands
3. Provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients/families to record results in the home setting where applicable
4. Provides or connects patients/families to self-management support programs
5. Provides or connects patients/families to classes taught by qualified instructors
6. Provides or connects patients/families to other self-management resources where needed
7. Provides written self management plan to the patient/family.

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

**Scoring**

100%	75%	50%	25%	0%
75%-100% of patients seen in the past 3 months have at least 3 activities documented including Factor 7)	50%-74% of patients seen in the past 3 months have at least 3 activities documented including Factor 7)	25%-49% of patients seen in the past 3 months have at least 3 activities documented including Factor 7)	11%-24% of patients seen in the past 3 months have at least 3 activities documented including Factor 7)	10% or less patients seen in the past 3 months have at least 3 activities documented including Factor 7)

**Data source** Records or files

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic

**Condition-specific:** No

**Details:** This element addresses the practice helping patients manage their health. This element goes beyond physician counseling or guidance during an office visit. The practice or its medical group may provide self-management programs or classes or the practice may refer the patient to community resources, when needed and available. The resources to where the practice refers patients may include resources that the practice knows are provided by the patient's health plan.

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

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

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

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

**Method 2—Review a sample of 36 medical records.**

1. Use the three important diagnoses and conditions identified. To determine important conditions, the practice analyzes its entire population. Clinically important conditions are chronic or recurring conditions that the practice sees. (Refer to Element 2E for further explanation of identifying clinically important conditions.)
2. Choose the weekday nearest the date one month prior to today.
3. Going either backward or forward from that date, select the first 36 patients who had a nonacute care visit and who have any one or more of the three chosen clinically important conditions. You will review these same 36 patient files for several elements.

Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions (see element 2E).

- Denominator = The sample of 36 patient medical records
- Numerator = The patients from the medical record review for whom at least three items are entered.

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

Examples of Item 1, assessing readiness to change, include questionnaires and self-assessment forms. Examples of Item 2 include a copy of the educational materials the practice has available for patients does not meet the intent of this item. The medical record must also indicate that the practice has provided materials to the patient.

Examples of Item 4, self-management programs, include weight loss and smoking cessation programs.

Examples of Item 5, classes taught by instructors, include diabetes and asthma education.

Examples of Item 6, other self management resources, include group visits, counseling and support groups.

## Examples

**Data source:** Medical record review includes:

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

## PPC 5: Electronic Prescribing

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

### Intent

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

### Element A: Electronic Prescription Writing

Tier II (optional)

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

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

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

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

### Scoring

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

**Data source** Reports

**Scope of review** ONCE— This element is scored once for the organization.

**Explanation** **IT required:** Intermediate

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

**Condition-specific:** No

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

- Denominator = Total number of prescriptions written for patients in the last 3 months
- Numerator = Number of new prescriptions written with the practice's prescribing system.

Prescription renewals may count as "new" prescriptions. If all of the practice's prescriptions are written electronically, the practice must provide a report showing use of the system for a specified percentage of patients.

The term **general** in all the prescribing elements refers to information about medications from standard data bases. The term **patient-specific** refers to information that is related or linked to data on a particular patient. The e-prescribing system includes e-faxing as long as it is not a hand-written prescription.

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

### Element B: Prescribing Decision Support—Safety

Tier II (optional)

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

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

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

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

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

**Source of content:** eHealth Initiative, US Pharmacopoeia

**Condition-specific:** No

**Details:** The practice's electronic system should alert clinicians to specific prescribing issues for patient safety.

Addressed by this element are:

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

In the future, national organizations may provide more specifications to standardize some of these types of alerts. Systems should have the capability of adding specific alerts as specifications become available.

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

**Element C: Prescribing Decision Support—Efficiency Tier II (optional)**

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

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

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

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

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

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

**Condition-specific:** No

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

**Examples** **Data source:** Reports from the system, screen shots, practice protocols.

## PPC 6: Test Tracking

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

### Intent

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

### Element A: Test Tracking and Follow-Up

Tier I (required)

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

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

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

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

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

<b>Explanation</b>	<b>IT required:</b> Basic if paper system, intermediate if electronic system within the office, advanced if interconnected with laboratory or radiology. <b>Condition-specific:</b> No <b>Details:</b> Whether the system is manual or electronic, there must be evidence that the practice reviews and uses the log before or at the beginning of every patient appointment. There must be evidence that the practice both follows up with the clinician and proactively notifies the patient of abnormal results; filing the report in the medical record for the next time the patient comes in does not meet the intent of the standard.
<b>Examples</b>	<b>Data source:</b> Reports or logs—may be a paper log or an electronic in-box showing outstanding tests and showing how the practice flags abnormal results.

## PPC 7: Referral Tracking and Coordination

The practice systematically documents and tracks referrals and referral results.

### Intent

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

### Element A: Referral Tracking and Coordination

Tier I (required)

The practice coordinates referrals designated as critical through the following:

	Yes	No
1. Providing the patient and consultant/specialist practitioner with the reason for the consultation and pertinent clinical findings	<input type="checkbox"/>	<input type="checkbox"/>
2. Tracking the status of the referral, including the timing for the referred service	<input type="checkbox"/>	<input type="checkbox"/>
3. Obtaining a report back from the practitioner	<input type="checkbox"/>	<input type="checkbox"/>
4. Asking patients about self-referrals and obtaining reports from the practitioner(s).	<input type="checkbox"/>	<input type="checkbox"/>

### Scoring

100%	75%	50%	25%	0%
Practice uses system that includes all 4 items	No scoring option	Practice uses system that includes 3 items	Practice uses system that includes 2 items	Practice uses system that includes 0-1 items

### Data source

Reports

### Scope of review

ONCE—This element is scored once for the organization.

### Explanation

**IT required:** Basic or Advanced (Basic for paper system; Advanced for electronic system).

**Source of content:** HL-7 functional standards

**Condition-specific:** No

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

- Reason for the consultation
- Pertinent clinical findings
- Support person
- Functional status
- Family history
- Social history
- Plan of care
- Health care providers.

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

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

**Examples**

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

## PPC 8: Performance Reporting and Improvement

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

### Intent

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

### Element A: Measures of Performance

### Tier II (optional)

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

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

### Scoring

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic

**Condition-specific:** No

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

The practice may use electronic systems to measure any of these items, but the element requires performance measurement whether or not electronic systems are available. Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not only those covered by one payer.

Practices with NCQA's Heart Stroke (HSRP) Recognition or Diabetes Physician (DPRP) Recognition may receive credit for measuring Item 1, clinical process and Item 2, clinical outcomes performance data. To receive credit, the HSRP and/or DPRP Recognition dates must be current at the time the practice submits its PPC-PCMH Survey Tool to NCQA. The practice should enter this information in the Support Text/Notes in the Survey Tool.

**Examples**

**Data source:** Reports from:

- Manual review of a sample of patient records
- Patient surveys
- Practice management system
- Registry
- Health plan-provided data
- Larger medical group provided data
- Electronic database.

**Element B: Patient Experience Data** **Tier II (optional)**

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

**Scoring**

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

**Data source**

Reports

**Scope of review**

ONCE—This element is scored once for the organization.

**Explanation**

**IT required:** Basic

**Condition-specific:** No

**Details:** Practices may use a phone survey or a paper or electronic survey. Patient access to care may include the ability to make an appointment and see a physician, timeliness and quality of phone calls, office wait time. Quality of physician communication may include response to questions, instructions and information about diagnosis, treatment, medication and follow up care. Practices may also incorporate questions about the degree to which patients and families feel that they are partners in the management of their health care.

Patient/family confidence in self-care may include patient knowledge of and ability to provide self-care involving activity, exercise, medications and reporting change in symptoms. Patient/family satisfaction with care may include satisfaction with staff, physician and others, satisfaction with treatment and satisfaction with response to patient/family choices. Performance results must reflect care provided to all patients cared for by the practice (relevant to the measure), not only those covered by one payer.

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

**Note:** Practices must provide summarized data. A blank survey form does not meet the intent of this requirement.

- Examples**
- Collect data using CAHPS Clinician and Group Survey
  - Convene patient advisory panel

**Element C: Reporting to Physicians Tier II (optional)**

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

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation**

**IT required:** Basic

**Condition-specific:** No

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

**Examples**

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

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**Element D: Setting Goals and Taking Action** **Tier II (optional)**

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

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

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT required:** Basic  
**Condition-specific:** No  
**Details:** The practice should base goal setting on its own measurements as in element 8A. Examples of actions taken include providing such assistance as flow sheets or decision support to clinicians to prompt more systematic treatment. Goal setting and taking action include periodic remeasurement to assess progress and promote continuous quality improvement. Practices may find it useful to involve patients and families in quality improvement activities.

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

## PPC 9: Advanced Electronic Communication

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

### Intent

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

### Element A: Availability of Interactive Web Site Tier II (optional)

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

Scoring	100%	75%	50%	25%	0%
	Practice provides 5-6 items	Practice provides 3-4 items	Practice provides 1-2 items	No scoring option	Practice does not provide any items

**Data source** Reports

**Scope of review** ONCE—This element is scored once for the organization.

**Explanation** **IT Required:** Intermediate  
**Condition-Specific:** No  
**Details:** This element looks at ways practices can provide Web-based functionality that support patient access and patient-self-management. Electronic communication should be secure.

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

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# Glossary

## APPENDIX 3

### PPC-PCMH GLOSSARY

<b>allergy</b>	An adverse reactions to a substance.
<b>business associate</b>	A person or organization that on behalf of a covered entity (health plan, health care clearinghouse or health care provider) or organized health care arrangement, which includes a covered entity, performs or assists in the performance of, but not in the capacity of a workforce member, functions or activities involving the use or disclosure of individually identifiable health information from the covered entity or organized health care arrangement.
<b>clinical visit data</b>	A record of patient activity at the practice.
<b>clinically important condition</b>	A chronic or recurring condition that a practice sees most frequently, such as otitis media, asthma, diabetes or congestive heart failure. The most frequently seen single-episode conditions may also be clinically important conditions such as colds or urinary tract infections.
<b>contact information</b>	Patient location facts that may include telephone number, e-mail address, payer ID and emergency contact information.
<b>demographic information</b>	Information that includes at least ethnicity, gender, marital status, date of birth, type of work, hours of work and preferred language.
<b>diagnoses</b>	A problem list of conditions, injuries or other health issues.
<b>documented process</b>	Written statements describing the practice's procedures. The statements may include protocols or other documents that describe actual processes or blank forms the practice uses in work flow such as referral forms, checklists and flow sheets.
<b>Emergency admission</b>	An unscheduled medical or behavioral health care event that results in either an emergency room visit or hospital admission.
<b>evidence-based guideline</b>	Clinical practice guidelines that are based on scientific evidence or, in the absence of scientific evidence, professional standards or, in the absence of professional standards, expert opinion. See <b>practice guidelines</b> .
<b>example</b>	A document, report or prepared material that illustrates implementation of systems or processes by the practice.
<b>factor</b>	An item within an element that is scored. For example, an element may require the organization to demonstrate that a specific document includes four items. Each item is a factor.
<b>materials</b>	Prepared material that the practice provides to patients, including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets.
<b>multi-site group</b>	Multiple practice sites of a larger organization that provide standardized systems across the practices. In this case, NCQA reviews some elements once and applies the results to all practice sites in the Multi-Site Group.
<b>population management</b>	The assessment of all patients in a practice to identify groups of patients who require specific services.

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<b>practice</b>	One physician or a group of physicians at a single geographic location who practice together. Practicing together means that, for all the physicians in a practice: 1.) The single site is the location of practice for at least the majority of their clinical time; 2.) Nonphysician staff follow the same procedures and protocols; 3.) Medical records, whether paper or electronic, for all patients treated at the practice site are available to and shared by all physicians as appropriate; 4.) The same systems—electronic (computers) and paper-based—and procedures support both clinical and administrative functions: scheduling time, treating patients, ordering services, prescribing, keeping medical records and follow-up.
<b>practice guidelines</b>	Systematically developed descriptive tools or standardized protocols for care to support practitioner 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 guidelines may also be called <i>practice parameters</i> , <i>treatment protocols</i> or <i>clinical guidelines</i> .
<b>preventive health data</b>	A patient's status regarding receipt of preventive screenings, immunizations and counseling appropriate for the patient's age and gender.
<b>records or files</b>	Actual patient medial files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element. There are two ways to measure this performance: 1.) a query of electronic files yielding a count, and 2.) the sample selection process provided by NCQA—instructions for choosing a sample and a log for reviewing records are in the Record Review Workbook.
<b>registry</b>	A searchable list of patient data that the practice actively uses to assist in patient care.
<b>reports</b>	Aggregated data showing evidence of action; may include manual and computerized reports.
<b>risk factors</b>	Behaviors, habits, age, family history or other factors that may increase the likelihood of poor health outcomes.
<b>sample</b>	A statistically valid representation of the whole.
<b>treatment plan</b>	A written action plan based on assessment data that identifies the patient's clinical needs, the strategy for providing services to meet those needs, the treatment goals and objectives.