Greenway SuccessEHS

Patient Centered Medical Home Toolkit for 2014 NCQA Standards
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Policy and Procedures

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Policy and Procedures

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Policy and Procedures

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Policy and Procedures

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Policy and Procedures

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Policy and Procedures

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Policy and Procedures

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SuccessEHS Recommendations (Factor 1)

Policy and Procedure

Factor 2: Assessing the language needs of its population

SuccessEHS Recommendations (Factor 2)

Policy and Procedure

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SuccessEHS Recommendations

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SuccessEHS Recommendations

Documentation

Reporting

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SuccessEHS Recommendations

Documentation

Reporting

Factor 3: The practice obtains feedback on the experiences of vulnerable patient groups

SuccessEHS Recommendations

Documentation

Reporting

Factor 4: The practice obtains feedback from patients/families through qualitative means

Documentation

Reporting

Element 6D: Implement Continuous Quality Improvement

Explanation

Factor 1: Set goals and analyze at least three clinical quality measures from Element A AND Factor 2: Act to improve at least three clinical quality measures from Element A

SuccessEHS Recommendations

Documentation

Reporting

Factor 3: Set goals and analyze at least one measure from Element 6B

SuccessEHS Recommendations

Documentation

Reporting

Factor 4: Act to improve at least one measure from Element 6B

Documentation

Reporting

Factor 5: Set goals and analyze at least one patient experience measure from Element 6C

SuccessEHS Recommendations

Documentation

Reporting

Factor 6: Act to improve at least one patient experience measure from Element 6C

SuccessEHS Recommendations

Documentation

Reporting

Factor 7: Set goals and address at least one identified disparity in care/service for identified vulnerable populations

SuccessEHS Recommendations

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Overview

The NCQA Patient Centered Medical Home (PCMH) is an innovative program for improving primary care in a set of 6 standards that align with core components of primary care. These standards describe specific criteria or elements for each of the 6 standards of care and give practices information about organizing care around patients, and coordinating in care teams who coordinate and track patient care. Many of the NCQA Patient Centered Medical Home standards are closely aligned with the Meaningful Use measures.

The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Note - This document is designed to provide guidance in obtaining Patient Centered Medical Home recognition through the National Committee for Quality Assurance (NCQA) based upon the 2014 standards as well as guide your clinic in changes or modifications to workflows or processes to implement and achieve PCMH recognition.

Some of these standards may require changes to workflows or processes; others will require changes to, or creation of, policies and procedures unique to your office. Included in this document is a listing of each Standard, the Elements within each Standard, and suggested workflow or process changes. In addition, a list of the necessary reporting processes to certify for each Standard is included.

As there is a closely aligned process with Meaningful Use, SuccessEHS is already able to produce much of the reporting necessary for certification or renewal.

The launch of the SuccessEHS 7.40 release contains greater enhancements to the software to facilitate the use or changes in workflow, making adoption of the PCMH certification process easier.

Standards

The PCMH standards are as follows:

- Patient-Centered Access
- Team-Based Care
- Population Health Management
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality
“Must Pass” Elements, Factors, and Critical Factors

The following six Elements contained within the aforementioned standards are essential, or “Must Pass,” in order to obtain PCMH recognition:

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 1, Element A</td>
<td>Patient-Centered Appointment Access</td>
</tr>
<tr>
<td>Standard 2, Element D</td>
<td>The Practice Team</td>
</tr>
<tr>
<td>Standard 3, Element D</td>
<td>Use Data for Population Management</td>
</tr>
<tr>
<td>Standard 4, Element B</td>
<td>Care Planning and Self-Care Support</td>
</tr>
<tr>
<td>Standard 5, Element B</td>
<td>Referral Tracking and Follow-Up</td>
</tr>
<tr>
<td>Standard 6, Element D</td>
<td>Implement Continuous Quality Improvement</td>
</tr>
</tbody>
</table>

Must Pass Elements are considered the basic building blocks of a Patient Centered Medical Home. Practices must earn a score of 50% or higher and pass all six Must-Pass Elements for recognition.

Factors are scored items contained within an Element to demonstrate how the practice team provides a range of patient care services.

Critical Factors are those Factors that must be met in each practice to receive any score on particular Elements.

Note - Must Pass Elements and Critical Factors are noted with a red triangle throughout this document.

Recognition Levels and Point Requirements

There are three levels of NCQA PCMH Recognition. Each level reflects the degree to which a practice meets the requirements of the Elements and Factors that compose the standards. For each Element’s requirements, NCQA provides examples and requires specific documentation.

NCQA Recognition levels allow practices with a range of capabilities and sophistication to meet the standards’ requirements successfully. The point allocation for the three levels is as follows:

<table>
<thead>
<tr>
<th>Recognition Level</th>
<th>Points</th>
<th>Must Pass Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>35-59 Points</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 2</td>
<td>60-84 Points</td>
<td>6 of 6</td>
</tr>
<tr>
<td>Level 3</td>
<td>85-100 Points</td>
<td>6 of 6</td>
</tr>
</tbody>
</table>
Eligibility

Patient-Centered Medical Home recognition is at the practice-site level; clinicians are not recognized individually. Thus, all data submitted to NCQA should reflect the practice site’s efforts, including a practice site total. If Meaningful Use Reports are used in reporting, they should be aggregated to site level. NCQA requires a completed survey tool for each site that the practice expects to identify as a recognized PCMH location.

NCQA defines a practice as one or more clinicians who practice together and provide patient care at a single geographic location. NCQA provides the following definition of practices and clinicians that qualify for PCMH:

Practicing together means that, for all the clinicians in a practice:

- The practice care team follows the same procedures and protocols.
- Medical records for all patients treated at the practice site, whether paper or electronic, are available to and shared by all clinicians, as appropriate.
- The same systems — electronic and paper-based — and procedures support both clinical and administrative functions, for example: scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up.
- A facility, such as a rehabilitation facility or a hospital cannot receive PCMH Recognition; however, hospital-based primary care practices and residency clinics are eligible.

Primary care practices that qualify for PCMH evaluation, include:

- An incorporated group of three clinicians in an office site who use the same systems and staff, as described above.
- An individual clinician, whether sharing an office with other clinicians or not, who maintains his or her own systems.
- A group of clinicians at one location that is part of a larger medical group with several locations
- A practice within a multi-site group; NCQA defines a multi-site group as 3 or more practice sites using the same systems and processes including an electronic medical record system shared across all practice sites.
- A subset of primary care clinicians within a multi-specialty practice.

Eligible primary care clinicians who qualify for PCMH evaluation, include:

- Only clinicians that a patient/family can select as a Personal Clinician are eligible for Recognition and listed on NCQA’s website.
- Clinicians who are typically eligible for PCMH evaluation include physicians, nurse practitioners and physician assistants who practice in the specialty of internal medicine, family medicine or pediatrics and with the intention of serving as the personal, primary care clinician for their patients.
- The practice may define a “personal clinician” as a residency group under a supervising clinician, although residents are not identified individually for selection as personal clinicians. The practice may define a personal clinician as a combination physician and nurse practitioner or physician assistant who share a panel of patients. These clinicians will be identified individually with the recognized practice.
- Clinicians who are not typically eligible for PCMH evaluation include specialty physicians, nurse practitioners and physician assistants who do not have their own panel of patients or who do not practice in primary care.
- All eligible clinicians practicing together at practice site applying for recognition must be included in the PCMH Application.
- Physician-led practices applying with nurse practitioners or physician assistants:
− Patients must be able to choose the nurse practitioner or physician assistant as the primary care practitioner.
− Nurse practitioner practices (NP-led practices) without a physician can achieve NCQA Recognition with the following considerations:
  ▪ It is allowed according to the scope of practice determined by state law.
  ▪ Practices are reviewed against the same requirements as physician-led practices.
− Applicants must have an active unrestricted licenses as a doctor of medicine, doctor of osteopathy, nurse practitioner or physician assistant.

Initial Recognition vs. Renewal

To acknowledge that practices with current NCQA Level 2 or Level 3 Recognition have taken steps toward practice redesign and have systems in place that enabled their recognition level, NCQA offers a streamlined process for renewal through reduced documentation requirements. Practices that satisfactorily demonstrated basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

Note - Even though some elements do not require a practice to submit documentation, the practice must be able to produce documentation if it is selected for audit.

Certifications

NCQA issues an official recognition certificate acknowledging that the practice met the standards.

Duration of Status

From NCQA Patient-Centered Medical Home (PCMH) 2014 Documentation Requirements for Upgrades to PCMH 2014 and Renewals:

Recognition status lasts three years. Clinics that want to achieve a higher level of recognition status can apply for an add-on survey. Please refer to the NCQA Patient Centered Medical Home Standards and Guidelines for complete instructions for the Add-on survey.

Recognition Levels

From NCQA Patient-Centered Medical Home (PCMH) 2011 Documentation Requirements for Upgrades to PCMH 2014 and Renewals:

- Recognized
- Not Recognized

The following sections of this toolkit provide guidelines on how to perform the required steps and provide documentation for each of the PCMH standards utilizing a combination of your clinic's policies and procedures and the SuccessEHS solution.

Each section includes a description of the standard as well as the Elements and Factors contained within that standard. You will also find example policies and procedures for your clinic, workflow recommendations to
perform and document required steps, and instructions on how to provide documentation to NCQA for each factor.

Table 1: Summary of NCQA PCMH 2014 Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered Access</td>
<td>The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.</td>
</tr>
<tr>
<td>Team-Based Care</td>
<td>The practice providers continuity of care using culturally and linguistically appropriate, team-based approaches.</td>
</tr>
<tr>
<td>Population Health Management</td>
<td>The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.</td>
</tr>
<tr>
<td>Care Management and Support</td>
<td>The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.</td>
</tr>
<tr>
<td>Care Coordination and Care Transitions</td>
<td>The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.</td>
</tr>
<tr>
<td>Performance Measurement and Quality</td>
<td>The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.</td>
</tr>
</tbody>
</table>

How to Use This Toolkit

The SuccessEHS PCMH Toolkit is designed to be used as a guide to fulfill all of the necessary requirements for achieving PCMH recognition through NCQA.

Each chapter in the Toolkit addresses a particular PCMH Standard. The Toolkit combines information taken directly from the *Standards and Guidelines for NCQA’s Patient-Centered Medical Home (PCMH) 2014* document, as well as workflows, recommendations, sample policies and procedures, and reporting tools specific to SuccessEHS.

The following sections describe how each chapter is constructed, what Elements are contained in each chapter, and how they can be used to satisfy the relevant recognition requirements.

Standard Definitions and Total Scores

Each chapter begins with the definition of the specific PCMH Standard being addressed. This information is taken directly from the NCQA language. In addition, a **Total score available** value indicates the total number of points that must be amassed to meet the requirements of the Standard:

Example: Standard definition/Total score

<table>
<thead>
<tr>
<th>2</th>
<th>PCMH Standard 1: Patient-Centered Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>From NCQA:</td>
<td>The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.</td>
</tr>
<tr>
<td>Total score available: 10 Points</td>
<td></td>
</tr>
</tbody>
</table>
Elements and Tables of Factors

The subsequent sections outline the individual Elements that comprise each Standard. Each Element contains a table of the individual Factors that make up the Element that must be met to pass the Element.

Example: Element and Table of Factors (language from NCQA)

**Element 1A: Patient-Centered Appointment Access**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Providing same day appointments for routine and urgent care.</td>
</tr>
<tr>
<td>2</td>
<td>Providing routine and urgent-care appointments outside regular business hours.</td>
</tr>
<tr>
<td>3</td>
<td>Providing alternative types of clinical encounters.</td>
</tr>
<tr>
<td>4</td>
<td>Availability of appointments.</td>
</tr>
<tr>
<td>5</td>
<td>Monitoring no show rates.</td>
</tr>
<tr>
<td>6</td>
<td>Acting on identified opportunities to improve access.</td>
</tr>
</tbody>
</table>

**VALUE:** 4.5 points

**SCORING:**

- The practice meets 5-6 factors (including factor 1).
- The practice meets 3-4 factors (including factor 1).
- The practice meets 2 factors (including factor 1).
- The practice meets 1 factor (including factor 1).
- The practice meets 0 factors.

Titles of Elements that have been designated as Must Pass items will appear in **red text** and be indicated with a **red triangle**: ⚠️

**Table of Factors**

The Table of Factors lists the description of the Element requirements and all Factors that must be met to complete the Element. As with Must Pass items, Critical Factors will appear in **red text** and be noted with a **red triangle** as illustrated above. Critical Factor numbers will **display in red** in the table.

- **Value:** The **Value** section displays the point value accorded to each Element.
- **Scoring:** The **Scoring** section displays the various percentage levels of completeness that may be obtained for the Element, depending on which Factors are met.

**Note** - Not all percentage levels are applicable for every Element. Levels designated as “No scoring level” indicate that the particular percentage of completeness is not available for that Element.

**Individual Factors**

The individual Factors are listed for each Element. Each Factor contains the following information:

**Factor Description (from NCQA)**

Factor descriptions are taken directly from the Standards and Guidelines for NCQA’s Patient-Centered Medical Home (PCMH) 2014 document.

Titles of any factors that have been designated as Critical Factors will appear in **red text**.
Example: Factor title and description (language from NCQA)

Factor 3: Providing alternative types of clinical encounters

From NCQA:

Factor 3: An alternative type of clinical encounter is a scheduled meeting, such as a billeable visit, between patient and clinician using a mode of real-time communication in lieu of a traditional one-on-one in-person office visit, for example, standalone communication or a combination of telephone, video chat and secure instant messaging. Group visits or shared medical appointment, where the patient is one of several patients scheduled for care at the same time also qualifies as an “alternative type of clinical encounter.”

Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, Web site) during office hours do not meet the requirement. An appointment with an alternative type of clinician (e.g., diabetic counselor) does not meet the requirement.

Example: Critical Factor title (in red text)

Factor 2: Providing timely clinical advice by telephone

Note - 

Factor 2 is a Critical Factor and must be met to achieve 25% or higher on this Element.

From NCQA:

Factor 2: Factor 2 is a critical factor and must be met for practices to score higher than 25% on this element.

Patients can seek and receive interactive (i.e., questions are answered by a person, rather than by a recorded message) clinical advice by telephone (factor 2) or secure electronic communication (factor 3) (e.g., electronic message, Web site) when the office is open and closed.

Clinicians return calls and respond to secure electronic messages in the time frame defined by the practice to meet the clinical needs of the patient population.

The practice may have different standards for when the office is open and when the office is closed and may have different standards for electronic versus telephonic communications.

Policy and Procedure

For those factors requiring a written policy and procedure, this section describes the type of written policy/procedure under which the practice must operate, along with the specific information that must be present in the document. Not all Factors require written policies and procedures; thus, this section will not appear for every Factor.

We have included as part of this toolkit many sample policy and procedures for your use. These policies and procedures are contained within separate documents within the toolkit, and will be referenced within this document when applicable.

SuccessEHS Recommendations

This section describes recommended workflows within SuccessEHS that users may follow to fulfill the particular Factor. Step-by-step workflows are included along with relevant illustrations where applicable.

Documentation (from NCQA)

This section will provide information on the type of information that must be documented to fulfill the Factor.

Note - Descriptions of the documentation required are taken directly from the Standards and Guidelines for NCQA’s Patient-Centered Medical Home (PCMH) 2011 document.
Documentation Types

Documentation requirements will include any of the five following documentation types:

1. **Documented process** – Written procedures, protocols, processes, and workflow forms (not explanations); these should show the practice name and date of implementation. All processes should be in place for at least 3 months prior to survey tool submission.

2. **Reports** – Aggregated data showing evidence. Reports should be at the site-level, not individual clinicians.

3. **Records or files** – Patient files or registry entries documenting action taken; data from medical records for important conditions

4. **Materials** – Information for patients or clinicians. (e.g., clinical guidelines, self-management educational resources)

5. **Screen shots** – Electronic “copy” may be used as examples (EHR capability), materials (Web site resources), reports (logs) or records (advice documentation)

Reporting

This section will describe the specific reporting tools available from SuccessEHS to report on the various Factors for certification. Reports may include pre-designed Success Practice Analytics (formerly known as Business Objects/Business Intelligence) reports, Meaningful Use reports, NCQA-provided worksheets, or a combination.

If you use the original Success Practice Analytics version (formerly the 6.5 Business Objects tool) for reporting, the PCMH Toolkit reports are available on the Greenway Customer Community. To access these files, log into the Customer Community and select the Content tab. You can filter the Content tab to display SuccessEHS Reports files to easily find the PCMH Toolkit reports.

If you use the latest version of Success Practice Analytics (formerly 4.1 Business Intelligence), the PCMH Toolkit reports are available in the SuccessEHS Report Repository located directly inside the reporting tool. To access the reports, go to the Folders section on the Documents tab and select the Success_EHS_Report_Repository folder. You can copy and paste the toolkit directly to your Client ID folder.

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**Note** - Please Note: The SuccessEHS Platform has received pre-validation for the 2014 PCMH standards. For a copy of the required information (letters and copy of the summary table for 2014), please contact Customer Support or your Customer Experience Manager.
PCMH Standard 1: Patient-Centered Access

From NCQA:

The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

Total score available: 10 Points

Element 1A: Patient-Centered Appointment Access

Note - Element 1A is a Must Pass item.

The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Providing same-day appointments for routine and urgent care.</td>
</tr>
<tr>
<td>2</td>
<td>Providing routine and urgent-care appointments outside regular business hours.</td>
</tr>
<tr>
<td>3</td>
<td>Providing alternative types of clinical encounters.</td>
</tr>
<tr>
<td>4</td>
<td>Availability of appointments.</td>
</tr>
<tr>
<td>5</td>
<td>Monitoring no show rates.</td>
</tr>
<tr>
<td>6</td>
<td>Acting on identified opportunities to improve access.</td>
</tr>
</tbody>
</table>

VALUE: 4.5 points

SCORING:

- 100%: The practice meets 5-6 factors (including Factor #1).
- 75%: The practice meets 3-4 factors (including Factor #1).
- 50%: The practice meets 2 factors (including Factor #1).
- 25%: The practice meets Factor #1 (not simply any single factor).
- 0%: The practice meets 0 factors.

Explanation

MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

The practice has a written policy for making appointments available for both urgent and routine issues. The policy states time requirements and defines “routine” and “urgent.” For example, the practice has a policy that
urgent issues are seen immediately and routine visits (e.g., new-patient physicals, return-visit exams to monitor mild acute and chronic conditions) are scheduled within seven days.

The practice triages patients to determine the urgency of a request for a same-day appointment; triage considers patient care need and preference.

Patients access the clinician and care team for routine and urgent care needs by office visit, by telephone or through secure electronic messaging.

Factor 1: Providing same-day appointments for routine and urgent care

Note - Factor 1 is a Critical Factor.

From NCQA:

Factor 1 is a critical factor and must be met for practices to receive a score on this element. Since this is also a must pass element, failure to meet factor 1 will result in denial of recognition.

The practice reserves time for same-day appointments (also referred to as “same-day scheduling”) for routine and urgent care based on patient preference and need.

Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement.

The practice has a process for scheduling same-day visits for patients with routine and urgent needs, and monitors use of same-day appointments to ensure that patients are able to use this feature.

Walk-in hours are an approach to patient access that allows the patient to come into the practice without prior notice. A practice can provide walk-in hours in addition to same day appointments; however, providing walk-in hours alone does not meet the requirement for providing same day appointments.

SuccessEHS Recommendations

Each practice must have certain time blocks in the day allocated to urgent or routine same day appointments. The report for this factor will not count any appointments made using the override feature, therefore you need to build a policy within your organization that allows same day appointments. Using a time block on the appointment book will trigger an override code and is not recommended.

An example might include having a policy that each day from 8-8:30am, 11-11:30am and 4-4:30pm are reserved for same day urgent or routine appointments.

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 1: NCQA reviews a documented process for scheduling same-day appointments that includes defining their appointment types. NCQA reviews a report with at least five days of data, showing the availability and use of same-day appointments for both urgent and routine care.
Reporting

Reporting for this Factor is available via Success Practice Analytics Report 1A1 – Apts. Scheduled Same Day vs. Total Apts. This report compares the number of same day appointments with the number of total appointments. This report includes all appointment types.

Factor 2: Providing routine and urgent-care appointments outside regular business hours

From NCQA:

**Factor 2:** The practice schedules appointments outside its typical daytime schedule. For example a practice may open for appointments at 7 a.m. or remain open until 8 p.m. on certain days or it may be open two Saturdays each month.

Providing extended access does not include:

– Offering daytime appointments when the practice would otherwise be closed for lunch (on some or most days).
– Offering daytime appointments when the practice would otherwise close early (e.g., a weekday afternoon or holiday).

The practice is expected to provide appointment times that meet the needs of its patients; for example, offering Saturday appointment times for both routine and urgent care to allow patients who work during the week to obtain annual exams or be seen for an upper respiratory infection.

Practices are encouraged to first assess the needs of their patients for appointments outside normal business hours and then to evaluate if these appointment times meet the needs of the patients.

If the practice is not able to provide care beyond regular office hours (e.g., a small practice with limited staffing), it may arrange for patients to schedule appointments with other (non-ER, non-urgent care) facilities or clinicians.

Suggesting that patients locate the nearest ER or urgent care facility does not meet the intent of this requirement.

SuccessEHS Recommendations

The **Office Hours Configuration** must be defined to indicate which time frames fall outside of office hours.

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 2:** NCQA reviews a documented process for staff to follow for arranging routine and urgent appointment access during extended hours with other practices or clinicians and provides a report showing extended hours availability or materials provided to patients demonstrating that the practice provides regular extended hours. NCQA reviews a report with at least five days of data, showing availability and use of appointments outside the normal hours of operation. A process for arranging extended hours access is not required if the practice site has regular extended hours.
Reporting

Reporting for this Factor is available via Report 1A2 – Appts After-Hours. This report tracks any appointments entered on the resource’s schedule in the Scheduling module that are scheduled outside of the office hours configured for that location.

Factor 3: Providing alternative types of clinical encounters

From NCQA:

**Factor 3:** An alternative type of clinical encounter is a scheduled meeting, such as a billable visit, between patient and clinician using a mode of real-time communication in lieu of a traditional one-on-one in-person office visit; for example, standalone communication or a combination of telephone, video chat and secure instant messaging. Group visits or shared medical appointment, where the patient is one of several patients scheduled for care at the same time also qualifies as an “alternative type of clinical encounter.”

Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, Web site) during office hours do not meet the requirement. An appointment with an alternative type of clinician (e.g., diabetic counselor) does not meet the requirement.

SuccessEHS Recommendations

You can document alternative clinical encounters by creating a corresponding appointment type in the System Administration module.

An example of this would be an appointment type of “TELEHEALTH.”

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 3:** NCQA reviews a documented process for arranging appointments for alternative types of encounters (e.g., telephone, group visits, video chat). NCQA reviews a report of encounter types and dates that includes frequency of scheduled alternative encounter types in a recent 30-calendar-day period.

Ad hoc telephone or e-mail exchanges do not meet the requirement.
Reporting

Reporting for the factor can be done through the Success Practice Analytics report 1A3-Altp Types-Clinical Enc. This report can be used to determine all alternative types of encounters based on Appointment Types that were scheduled for patients during a selected time frame. A prompt is available for you to select your alternative appointment type codes when generating the report.

Factor 4: Availability of appointments

From NCQA:

**Factor 4:** The practice has standards for appointment availability. Availability standards may be established and measured for a variety of appointment types, including urgent care, new patient physicals, routine exams and return-visit exams or the practice may set a single standard across all appointment types (e.g. open access for all). One common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type, with an open-access goal of zero days (same-day availability).

The third next available appointment measures the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on the clinician’s schedule. The Institute for Healthcare Improvement (IHI) identified third next available appointment tracking as “a more sensitive reflection of true appointment availability.” IHI has set a goal of zero days for primary care. A clinician’s panel may be closed, but appointment availability may not be based on payer.

SuccessEHS Recommendations

**Reporting Option 1:** SuccessEHS captures the appropriate data to calculate the “third-next available” appointment. The “third-next appointment” is measured by the length of time from when a patient contacts his practice to request an appointment to the third next available appointment on his/her clinician’s schedule. To illustrate same-day scheduling, this value should be zero.

You can capture third-next appointments by configuring the Appointment Types database in the System Administration module:

System Administration > Scheduling Tables > Scheduling Appointment Types

1. Select (check) the Patient Access Reporting checkbox for all appointment types that must be reported on for your clinic.
   Examples of appointment types include New Patients, age appropriate preventative care, well child checkup, etc.

**Note - This step is only necessary if using Reporting Option 1 (see Reporting Section).**
Reporting Option 2: Utilize your current workflow for scheduling appointments in the Scheduling module.

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

Factor 4: NCQA reviews a documented process defining the practice’s standards for timely appointment availability (e.g., within 14 calendar days for physicals, within 2 days for follow-up care, same day for urgent care needs) and for monitoring against the standards. NCQA reviews a report with at least five days of data showing appointment wait times, compared with defined standards.

Reporting

OPTION 1: PATIENT ACCESS REPORT

Reporting for this Factor is available via the Patient Access Report in the Scheduling module, which calculates the third next available appointment:

1. Access the Scheduling module.
2. Select Print > Reports > Miscellaneous from the Scheduling menu.
3. The reports screen will open. Select the Patient Access Metrics report and enter the appropriate criteria. Click Preview or Print Now.

This report displays the number of days to the third next appointment using the numbers calculated each Wednesday for each appointment type that has the Patient Access Reporting checkbox checked.

Note - Each available month column on the report displays a number that is the average number of days from the current (today’s) date to the third next available appointment. This number is updated every Wednesday morning (at 12:01 a.m.) by running a job to calculate the number of days to the third next available appointment for all appointment types designated as Patient Access Reporting. Each week’s number is then averaged to arrive at the monthly number of days.

OPTION 2: AVAILABILITY OF APPOINTMENTS

Reporting for this Factor is available via Success Practice Analytics Report 1A4 – Availability of Appointments. This report displays the average time between when an appointment was scheduled and the day of the actual appointment.

If you are using this report in the latest version of Success Practice Analytics (formerly Business Intelligence 4.1), you can use the following steps to adjust the report to display the summary data:

1. After the report has been refreshed, it is set up to be displayed in Outline mode. This allows you to collapse and expand each Appointment Type section to see the details or the summary data.
2. To collapse an Appt Type section, click on the Appt Type Code and the Collapse and Expand arrows will display on the left-hand side of the report:

![Image of Appt Type section]

**1A4 - Availability of Appointments**

1/1/14 to 1/7/14

When generating this report, select "Financial Patients" for any Context of Query.

This report displays the average time between when an appointment was scheduled and the day of the actual appointment. This report includes a beginning and ending date prompt along with a prompt for the Scheduling Type Code, and Scheduled Location.

<table>
<thead>
<tr>
<th>Appt Type</th>
<th>Patient #</th>
<th>Appt Scheduled On</th>
<th>Appt Date</th>
<th>Sched On Dttm to Appt Dttm</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULTM</td>
<td>11937</td>
<td>06-Jan-14 09:15 AM</td>
<td>06-Jan-14 10:20 AM</td>
<td>00:05:15</td>
</tr>
<tr>
<td></td>
<td>13779</td>
<td>06-Jan-14 09:11 AM</td>
<td>06-Jan-14 10:00 AM</td>
<td>00:08:50</td>
</tr>
</tbody>
</table>

3. To collapse the data so that only the totals for that appointment type displays, click the arrow closest to the report data (the one on the right). This will collapse the individual patient details allowing only the totals to display.

![Image of collapsed Appt Type section]

**1A4 - Availability of Appointments**

1/1/14 to 1/7/14

When generating this report, select "Financial Patients" for any Context of Query box that displays.

This report displays the average time between when an appointment was scheduled and the day of the actual appointment. The report includes a beginning and ending date prompt along with a prompt for the Scheduling Resource, Appointment Type Code, and Scheduled Location.

<table>
<thead>
<tr>
<th>Appt Type</th>
<th>Patient #</th>
<th>Appt Scheduled On</th>
<th>Appt Date</th>
<th>Sched On Dttm to Appt Dttm</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULTM</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appts: 6</td>
<td>Avg Days/T from Schedule to Appt Dttm</td>
<td>0 d 0 h 55 m</td>
<td></td>
</tr>
</tbody>
</table>

4. Repeat step 3 for all Appt Type sections you’d like to collapse and only display the totals for. **(Note: If you save the report with collapsed Appt Types, those appointment types will remain collapsed each time you refresh the report and use them in the selection criteria.)**

5. Once you collapse an Appt Type section, you can always go back and expand that section to view the details. To do this, select the Appt Type Code and click the arrow to the right to expand the data.

**Note** - This report also includes a tab displaying the data by Resource. You can use the above instructions for collapsing/expanding Appt Type sections for each Resource.

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**Factor 5: Monitoring no-show rates**

**From NCQA:**

**Factor 5:** To provide consistent access and help understand true demand, practices monitor no-show rates. No-show rates may be calculated by taking the number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e. a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time (Primary Care Development Corporation).

**SuccessEHS Recommendations**

SuccessEHS can capture No Show appointments in the **Scheduling** module. To mark an appointment as “patient no show”:

1. Open the desired appointment book.
2. Right-click the appointment and select **Mark Patient As No Show**. The **Change Appointment** dialog box displays.

A clinic can also configure their system to automatically mark appointments as no show after a certain time frame. To do this:

1. Go to Clinical Console – System Administration Mode and choose Practice Configuration in the bottom left corner.

2. Select Configure SuccessEHS from the Navigation Tree and then select Scheduling.

3. Within the Appointment Change Definitions group, there is an option to define the time frame for when an appointment should automatically marked as No Show.

Any appointment not checked in after the allotted time frame will automatically be given a no show status.

**Documentation**

**From NCQA:**

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 5:** NCQA reviews a documented process for monitoring scheduled visits. NCQA reviews a report from a recent 30-calendar-day period showing number of scheduled visits; number of patients actually seen, number of no-shows; and a calculated rate using scheduled visits as the denominator and patients seen as the numerator or by taking the number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e. a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time.
Reporting

Reporting for this Factor is available via Success Practice Analytics Report 1A5 – Monitoring No Show Rates. This report gives the No Show Rate by taking the number of those who did not keep their pre-scheduled appointments during a selected period of time and comparing them to the total number of appointments that were pre-scheduled.

Factor 6: Acting on identified opportunities to improve access

From NCQA:

**Factor 6**: To expand access and capacity, the practice uses information gathered from reports in factors 1–5 to identify opportunities to improve access.

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

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 6**: NCQA reviews a documented process for selecting, analyzing and updating its approach to creating access to appointments that considers appointment supply and patient demand by:

- Including criteria for selecting areas of focus.
- Describing how the practice monitors areas of focus.
- Describing how the practice sets targets for improvement.
- Specifying how often criteria for creating greater access to appointments are revisited.
- Outlining when targets may be adjusted.

NCQA reviews a report showing the practice has evaluated data on access, selected at least one opportunity to improve access and took at least one action to create greater access.

Reporting

Reporting for this Factor is done by a practice creating a documented process that shows the above documentation criteria.
Element 1B: 24/7 Access to Clinical Advice

The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Providing continuity of medical record information for care and advice when the office is closed.</td>
</tr>
<tr>
<td>2</td>
<td>Providing timely clinical advice by telephone.</td>
</tr>
<tr>
<td>3</td>
<td>Providing timely clinical advice using a secure, interactive system.</td>
</tr>
<tr>
<td>4</td>
<td>Documenting clinical advice in patient records.</td>
</tr>
</tbody>
</table>

**VALUE:** 3.5 points

**SCORING:**

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>The practice meets all 4 factors.</td>
<td>The practice meets 3 factors (including Factor #2).</td>
<td>The practice meets 2 factors (including Factor #2).</td>
<td>The practice meets 1 factor (or does not meet Factor #2).</td>
<td>The practice meets no factors.</td>
</tr>
</tbody>
</table>

**Factor 1: Providing continuity of medical record information for care and advice when the office is closed**

*From NCQA:*

*Factor 1:* The practice makes patient clinical information available to on-call staff, external facilities, and other clinicians outside the practice when the office is closed. Access to the medical record may include direct access to the paper or electronic record or by arranging a telephone consultation with a clinician who has access to the medical record.

If care is provided by a facility that is not affiliated with the practice or does not have access to patient records, the practice provides patients with an electronic or printed copy of a clinical summary of their medical record. One option may be for patients to convey needed information via individualized care plans or portable personal health records, or through patient access to an electronic health record (EHR).

Telephone consultation with the primary clinician or with a clinician who has access to the patient’s medical record meets the requirement. The practice’s process for ensuring access includes a method for ensuring access by practice clinicians when the office is closed.
SuccessEHS Recommendations

There are multiple features in the SuccessEHS system that will allow practices to meet this measure. The implementation of the Patient Portal and timely sign off of encounters will insure that the patient has access to their electronic copy of health information from the Portal. The following steps describe how a patient can access their health information from the Patient Portal.

**OPTION 1: PATIENT PORTAL – CLINICAL SUMMARIES**

Within Clinical Console, a user can use the HIE Actions icon in the ribbon to send a clinical summary document to the portal if the selected patient has a portal account.

Administrators may also configure the system for a given provider so that clinical summaries are automatically sent to a patient’s portal (if the selected patient has a portal account configured).

Within Clinical Console, go to **Security mode > Compliance Configuration > Documents**:

![HIE Actions Icon](image)

Select the **Auto Send** option shown above and assign this rule to the provider(s) in the practice that wish to have this done automatically. The administrator can set the appropriate trigger that will push the summaries to the portal.

This will allow patients to have each encounter summary accessible after hours.

**OPTION 2: PATIENT PORTAL – ECOPY REQUESTS**

**Requesting an Electronic Copy of Patient Health Information via the Patient Portal**

1. To request an electronic copy of a patient’s PHI, select **Health Information Requests** on the **Health Information** page of the Portal. The **Health Information Requests** page displays.

![Request Health Information](image)

2. Click the Request an Electronic Copy of My Health Information button.
A table displaying the **Request Date** and completion status (in the **Is Complete** column) will display in the **Health Information History** section.

A “**Patient health information request processed successfully**” message will also display.

3. If the user clicks the button again while a current request is pending, they will be prompted to wait until the current request is complete before making another request. Multiple completed requests (if made by the portal user) will display in the table.

4. The user can click the specific **Download** link for past PHI documents to download older copies of the patient’s PHI, if needed.

5. When the request is completed (the provider must sign off on all encounters), the **Is Complete** column will display a **Y** (Yes), and the **Delivery Date** will display the date/time the information was uploaded to the Portal. The portal user can click the **Download** link to download a copy of the patient’s PHI.

**OPTION 3: SPECIFIED VIEW ACCESS**

A benefit of SuccessEHS is that users have 24/7 access to PHI. This insures that on-call staff are always able to access the patient’s health information, even after hours.

If care is provided by a facility that is not affiliated with the practice, then a special setup is available to grant an outside provider limited access to the system. This will allow non-affiliated caregivers to view patient data through the **Specified View** module, while limiting all other access to the system. If you are interested in implementing this special feature, please contact the SuccessEHS Support Department for more information.

**Documentation**

**From NCQA:**

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 1:** NCQA reviews a documented process for giving staff and patient’s access to medical record information for care and advice when the office is closed.
Reporting

Reporting for this factor is accomplished by providing the documented process as described in the Documentation section above.

Factor 2: Providing timely clinical advice by telephone

Note - Factor 2 is a Critical Factor and must be met to achieve 25% or higher on this Element.

From NCQA:

Factor 2: Factor 2 is a critical factor and must be met for practices to score higher than 25% on this element.

Patients can seek and receive interactive (i.e., questions are answered by a person, rather than by a recorded message) clinical advice by telephone (factor 2) or secure electronic communication (factor 3) (e.g., electronic message, Web site) when the office is open and closed.

Clinicians return calls and respond to secure electronic messages in the time frame defined by the practice to meet the clinical needs of the patient population.

The practice may have different standards for when the office is open and when the office is closed and may have different standards for electronic versus telephonic communications.

SuccessEHS Recommendations

This factor requires your clinic to create and document a policy regarding what it considers a timely response to the patient. You will also need a documented process for staff to follow in providing timely responses by telephone.

You can find a sample policy in the document titled "Providing Timely Clinical Advice by Telephone During Office Hours", which is included as part of this toolkit.

In order to meet and track this factor using SuccessEHS, you must capture office hour information and phone calls within the system.

CAPTURING OFFICE HOURS

1. In Clinical Console, Select the System Administration Console from the navigation icon.

2. Select Practice Configuration.
3. Select Office Hours Configuration.

DOCUMENTING MEDICAL MESSAGES WITHIN SUCCESSEHS

In order to track the timely response to patients through telephone calls, those telephone calls must be documented within SuccessEHS. The phone call list should be frequently reviewed and updated in accordance with your clinic’s policies and procedures. Responses to patients should be documented in the Reply to Patient field for accurate reporting.

CREATING A MEDICAL MESSAGE

1. Access the Medical Messages section in Clinical Console.
2. Click the Create Medical Message button in the menu ribbon.
3. Using the Find Patient dialog, select the desired patient.
4. Verify the correct contact phone number.
5. Route the phone call to correct clinical person (nurse/MA/triage).
6. In the Reason field, indicate the reason for the call. Initial your note.
7. Mark the call Urgent if needed (call will save in red text).
8. Click Send/Save to send the call.
VIEWING YOUR ASSIGNED MEDICAL MESSAGES

1. Access Medical Messages in Clinical Console.
2. Messages will be listed at the top; urgent messages will display in red text.
3. Select the message with a single-click and the details will appear in the bottom window.

WORKING YOUR MEDICAL MESSAGES

1. Access the Medical Messages section in Clinical Console.
2. Messages will be listed at the top (urgent calls will display in red).
3. Document the message advice and sign off or re-assign the message to the appropriate staff.
4. Select the message and details will appear in the bottom window.

DOCUMENTING A REPLY TO A PATIENT

1. Select the message within your Medical Messages list.
2. Enter the information you provided to the patient into the Reply to Patient field.

The date and time that you replied to the patient will default to the date/time that you began entering
your response. If the patient response was at a different time, this field should be updated appropriately.

3. Save and sign off the message.

**Note** - Users must be granted access to the Reply to Patient field in order to document their response to the patient.

To view the Reply to Patient field:

1. In Clinical Console, select **Security Console**.

2. Select the **User** from the drop-down menu.

3. Select **+** next to the **Miscellaneous** section.

4. Select (check) the box next to **Reply to Patient**.

**Documentation**

**From NCQA:**

**Factor 2:** NCQA reviews a documented process for providing timely clinical advice to patients by telephone, whether the office is open or closed.

The practice:

– Defines the time frame for a response.

– Monitors the timeliness of the response against the practice’s time frame.

NCQA reviews a report summarizing the practice’s response times for at least seven calendar days, during office hours and when the office is closed. The report may be system generated.
Reporting

Reporting for this Factor is available via the Success Practice Analytics Report 1B2 – Providing Timely Clinical Advice by Phone. This report can be used to track the response times to medical phone calls entered during or after office hours. Medical calls entered from the Patient Portal are not included in this report.

1. If you are using this report in the latest version of Success Practice Analytics (formerly Business Intelligence 4.1), you can use the following steps to adjust the report to display the summary data:

2. After the report has been refreshed, it is set up to be displayed in Outline mode. This allows you to collapse and expand each During Office Hours (Yes, No or Not Configured) section to see the details or the summary data. (Note: If you have the value “Not Configured”, you do not have office hours configured for the location. Steps for configuring office hours are available in the details of this factor.)

3. To collapse a During Office Hours section, click on the Yes, No or Not Configured value and the Collapse and Expand arrows will display on the left-hand side of the report:

4. To collapse the data so that only the totals for that During Office Hours section displays, click the arrow closest to the report data (the one on the right). This will collapse the individual patient details allowing only the totals to display.

5. Repeat step 3 for all During Office Hours sections you’d like to collapse and only display the totals for. (Note: If you save the report with collapsed During Office Hours sections, those will remain collapsed each time you refresh the report.)

6. Once you collapse a During Office Hours section, you can always go back and expand that section to view the details. To do this, select the Yes, No or Not Configured During Office Hours value and click the arrow to the right to expand the data.
Factor 3: Providing timely clinical advice using a secure, interactive electronic system

From NCQA:

Factor 3: If patients can submit requests for clinical advice after office hours, the practice has an obligation to provide a timely response. The practice defines the types of inquiries that should be made electronically, and its response time frame (e.g., a secure message sent after hours receives an automatic reply informing the sender that urgent situations require a phone call and that “routine” electronic messages will be responded to the next business day).

NCQA Patient-Centered Medical Home (PCMH) 2014 April 13, 2015:

Factor 3 is NA if the practice cannot communicate electronically with patients. The practice provides a written explanation for an NA response in the Support Text/Notes box in the Survey Tool. The practice must also respond ‘No’ to Element 1C factor 5.

SuccessEHS Recommendations

PROCESSING QUESTIONS SUBMITTED VIA PORTAL

When a patient submits a question via the Patient Portal, a medical message record will be logged in Clinical Console. If a patient calls the clinic, the phone call should be recorded in Medical Messages. In either case clinical advice should be documented on the medical message allowing the system to record the date and time that the advice was provided.

To document clinical advice given on the medical message record:

1. Select the message from your Medical Messages screen.
2. Enter the reply that you would like to provide to the patient in the Reply to Patient field. This field is only available to users with appropriate security access.
3. Save and sign off the reply.

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.
Factor 3: NCQA reviews a documented process for providing timely clinical advice to patients using a secure interactive electronic system, whether the office is open or closed.

The practice:
- Defines the time frame for a response.
- Monitors the timeliness of the response against the practice’s time frame.

NCQA reviews a report summarizing the practice’s response times for at least seven calendar days. The report may be system generated.

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report 1B3 – Providing Timely Clinical Advice – Electronically. This report can be used to track the response times to portal messages entered during or after office hours.

If you are using this report in the latest version of Success Practice Analytics (formerly Business Intelligence 4.1), you can use the following steps to adjust the report to display the summary data:

1. After the report has been refreshed, it is set up to be displayed in Outline mode. This allows you to collapse and expand each During Office Hours (Yes, No or Not Configured) section to see the details or the summary data. (Note: If you have the value “Not Configured”, you do not have office hours configured for the location. Steps for configuring office hours are available in the details of this factor.)

2. To collapse a During Office Hours section, click on the Yes, No or Not Configured value and the Collapse and Expand arrows will display on the left-hand side of the report:

3. To collapse the data so that only the totals for that During Office Hours section displays, click the arrow closest to the report data (the one on the right). This will collapse the individual patient details allowing only the totals to display.

4. Repeat step 3 for all During Office Hours sections you’d like to collapse and only display the totals for. (Note: If you save the report with collapsed During Office Hours sections, those will remain collapsed each time you refresh the report.)
5. Once you collapse a During Office Hours section, you can always go back and expand that section to view the details. To do this, select the Yes, No or Not Configured During Office Hours value and click the arrow to the right to expand the data.

Factor 4: Documenting clinical advice in patient records

From NCQA:

Factor 4: The practice documents all clinical advice in the patient record, whether it is provided by phone or by secure electronic message during office hours and when the office is closed. If a practice uses a system of documentation outside the medical record for after-hours clinical advice, it reconciles this information with the medical record on the next business day.

SuccessEHS Recommendations

OPTION 1: MEDICAL MESSAGES

Clinical Advice can be documented in the patient’s record by documenting all relevant information in the Reason field of a Medical Message. Advice given to the patient should be documented in the Reply to Patient field.

Once a message is saved and signed off, it is saved to the patient’s record. Messages can be accessed for a patient through Patient Messages Overview icon on the Patient Messages ribbon.

OPTION 2: MEDICAL MESSAGE ENCOUNTER

This factor requires you to document after-hours clinical advice provided to the patient in the patient’s chart. This can be accomplished by creating a message encounter and using a Reason for Encounter of Clinical Advice. You must also have your Office Hours configured in the database for use in PCMH reporting.
OFFICE HOURS CONFIGURATION

The Office Hours Configuration listed in Element A, Factor 1 must be defined to indicate which time frames fall outside of office hours. Once the office hours are defined, any patient requests that originate outside the defined hours can be captured and the after-hours time recorded in the system by creating a medical phone call in Clinical Console.

CREATING A MESSAGE ENCOUNTER

1. Select the message for which you have documented clinical advice from your Medical Messages list in Clinical Console.
2. Click Create Message Encounter.
3. Choose whether or not you would like the encounter to be billable.

4. An encounter will be created in Chart and the Encounter Detail screen will launch.
5. Your Type of Documentation will default to Messages, and the Reason for Encounter will populate in the Chief Complaint field.

6. Select a Reason for Encounter of Clinical Advice. (NOTE: The Clinical Advice reason will need to be built into your system if it is not already present.)
7. Document clinical advice as well as any other relevant documentation within the Notes field.

ADDING A REASON FOR ENCOUNTER

1. From Clinical Console, select the Navigation icon and select System Administration Console. The Clinic Configuration task list appears.
2. Click Reason for Encounter.
3. To add a new reason, click New. A new line will be enabled in the Description column for you to enter a new reason.

**Note** - When adding “Clinical Advice”, you must only capitalize the “C” and “A” in order for the report to pull data accurately.

4. Click Save.

**Documentation**

**From NCQA:**

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 4:** NCQA reviews a documented process for recording clinical advice in the patient record. NCQA reviews at least three examples of clinical advice documented in the patient record; at least one example shows documentation of advice provided when the office was closed and at least one example shows documentation of advice provided during office hours.

**Reporting**

**DOCUMENTED PROCESS AND THREE EXAMPLES**

Reporting for this Factor is accomplished by providing a documented process and at least three examples of clinical advice documented in the patient record. This can be accomplished by submitting screenshots of Medical Messages saved in **Patient Messages Overview** and/or **Chart**.
3  PCMH Standard 2: Team-Based Care

From NCQA:

The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

Total score available: 12 Points

Element 2A: Continuity

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assisting patients/families to select a personal clinician and documenting the selection in practice records.</td>
</tr>
<tr>
<td>2</td>
<td>Monitoring the percentage of patient visits with selected clinician or team.</td>
</tr>
<tr>
<td>3</td>
<td>Having a process to orient new patients to the practice.</td>
</tr>
<tr>
<td>4</td>
<td>Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care.</td>
</tr>
</tbody>
</table>

VALUE: 3 points

SCORING: 100% | 75% | 50% | 25% | 0%

From NCQA:

Patients and their families can select a personal clinician who works with a defined health care team. The selection is documented in the patient’s record. Practice staff are aware of a patient’s personal clinician or team and work to accommodate visits and communication. The practice monitors the percentage of patient visits with the designated clinician or team.

A team is a primary clinician and associated clinical (including behavioral healthcare providers) and support staff who work with the clinician. A personal clinician may represent a physician/mid-level clinician or medical residency group under a supervising physician, who share a panel of patients.

Note: Solo practitioners mark “yes” for factors 1 and 2 and indicate they are the only clinician available to patients at the practice in the Support Text/Notes box in the Survey Tool.

Factor 1: Assisting patients/families to select a personal clinician and documenting the selection in practice records

From NCQA:

Factor 1: The practice provides patients/families/caregivers with information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice documents the patient/family’s choice of clinician.
If patient-preference or staffing arrangement results in the need for more than one clinician to be identified, the practice may document a defined pairing of clinicians (e.g. physician and nurse practitioner or physician and resident) or a practice team.

SuccessEHS Recommendations

You must provide a sample of a Policy and Procedure used within your clinic that addresses notification of patients about the process for choosing a personal clinician and care team.

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submission of PCMH 2014 Survey tool.

**Factor 1:** NCQA reviews the practice’s documented process for patient and family selection of a personal clinician, and reviews an example of a patient record that documents patient/family choice of personal clinician.

Reporting

Reporting for this Factor is accomplished by providing the relevant policy and procedure as defined in the *SEHS Recommendations* section above.

**Factor 2: Monitoring the percentage of patient visits with selected clinician or team**

From NCQA:

**Factor 2:** The practice monitors the percentage of patient visits that occur with a personal clinician, including structured electronic visits (e-visits) and phone visits. The practice may determine the appropriate rate of continuity, based on the practice design, staffing model and patient preferences.

SuccessEHS Recommendations

Patients’ selected personal clinicians/teams are recorded via the *Doctor of Record* field in *Patient Administration*. 

![Patient Administration](image-url)
Documentation

From NCQA:

**Factor 2:** NCQA reviews a report with at least five days of data, showing the total percentage of patient encounters that occurred with personal clinicians.

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report **2A2-Pt Visits with Dr of Record.** This report compares the number of visits where the Examining Provider and Doctor of Record are the same to those where they are not. Users can get a total as well as a break-down by doctor of record along with the percentages.

**Factor 3: Having a process to orient new patients to the practice**

From NCQA:

**Factor 3:** The practice has an orientation process for patients new to the practice. Orientation provides information about the medical home model, medical home responsibilities and patient responsibilities and expectations.

SuccessEHS Recommendations

Create a documented process that describes how a practice orients new patients to the practice.

Documentation

From NCQA:

**Factor 3:** NCQA reviews the practice’s documented process for orienting patients to the practice.

Reporting

Reporting for this Factor is done through the practice creating a documented process that gives new patients pertinent information such as medical home model, medical home responsibilities, and patient responsibilities and expectations.

**Factor 4: Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care**

From NCQA:

**Factor 4:** For pediatric practices transitioning patients to adult care, the practice provides a written care plan to the adult practice that may include:

- A summary of medical information (e.g., history of hospitalizations, procedures, tests).
- A list of providers, medical equipment and medications for patients with special health care needs.
- Obstacles to transitioning to an adult care clinician.
- Special care needs.
- Information provided to the patient about the transition of care.
- Arrangements for release and transfer of medical records to the adult care clinician.
- Patient response to the transition.

Internal medicine practices receiving patients from pediatricians are expected to review the transition plan provided by pediatric practices and ensure that continued care is provided to adolescent and young adult patients.

For family medicine practices that do not transition patients from pediatric to adult care, the practice should instead inform patients and families about the concept of the medical home, and the importance of having a primary care clinician to provide regular, evidence-based preventive care and acute adolescent care management. Sensitivity to teen privacy should be incorporated into information provided to teens.

**SuccessEHS Recommendations**

For pediatric practices, use Patient Correspondence to create a written transition plan from pediatric to adult care.

For family and internal medicine practices, create a documented process and/or materials that meet the criteria specified below in the Documentation section.

**Documentation**

*From NCQA:*

- **Factor 4:** For pediatric practices, NCQA reviews an example of a written transition plan from pediatric to adult care.

  For family medicine practices, NCQA reviews a documented process and materials for outreach to adolescent and young adult patients to ensure continued preventive, acute and chronic care management.

  For internal medicine practices, NCQA reviews a documented process and materials for receiving adolescent and young adult patients that ensures continued preventive, acute and chronic care management.

**Reporting**

Reporting for this Factor is done through the practice creating a documented process that meets the requirements listed above under the “Documentation” section for your practice type.

**Element 2B: Medical Home Responsibilities**

The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The practice is responsible for coordinating patient care across multiple settings.</td>
</tr>
<tr>
<td>2</td>
<td>Instructions for obtaining care and clinical advice during office hours and when the office is closed.</td>
</tr>
<tr>
<td>3</td>
<td>The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.</td>
</tr>
<tr>
<td>4</td>
<td>The care team provides access to evidence-based care, patient/family education and self-management support.</td>
</tr>
</tbody>
</table>
5 The scope of services available within the practice including how behavioral health needs are addressed.

6 The practice provides equal access to all of their patients regardless of source of payment.

7 The practice gives uninsured patients information about obtaining coverage.

8 Instructions on transferring records to the practice, including a point of contact at the practice

VALUE: 2.5 points

SCORING:  
100% 75% 50% 25% 0%

- The practice meets 7-8 factors.
- The practice meets 5-6 factors.
- The practice meets 3-4 factors.
- The practice meets 1-2 factors.
- The practice meets no factors.

Explanation
The practice has a documented process for giving patients/families/caregivers information about the role and responsibilities of the medical home:

- Specific services patients can expect from the practice.
- Whom to contact for specific concerns, questions and information.
- The roles of the care team.

The practice is encouraged to provide information in multiple formats to accommodate patient preference and language needs.

Factor 1: The Practice is responsible for coordinating patient care across multiple settings.

From NCQA:

Factor 1: The practice coordinates care across settings (i.e., specialists, hospitals, rehab centers and other facilities), including for behavioral health.

Policies and Procedures
The practice is responsible for coordinating care across settings. Your practice must provide a written policy and procedure for disseminating information and materials addressing the obligations of a medical home, along with examples of such materials (e.g. brochures, written statements, website, etc.).

Documentation
From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.
Factors 1–8: NCQA reviews:

- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
  - Patient brochure.
  - Letter to the patient/family/caregiver.
  - Web materials.
  - A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
  - A sample record transfer request form.

**Reporting**

Reporting for this Factor is done by providing the process and materials listed above in the *Policies and Procedures* section. NCQA requests that the practice identify information relevant to this factor in the documentation.

**Factor 2: Instructions on obtaining care and clinical advice during office hours and when the office is closed**

*From NCQA:*

**Factor 2:** The practice:

- Provides information about its office hours; where to seek after-hours care; and how to communicate with the personal clinician and team, including requesting and receiving clinical advice during and after business hours.
- Instructs its patients to give their other providers or facilities the personal clinician’s information when they seek care outside the practice.

**Policies and Procedures**

The practice is responsible for providing its patients with materials such as office hours information, how to communicate with the care team, and how to seek after hours care. Your practice must provide a written policy and procedure for disseminating information and materials addressing the obligations of a medical home, along with examples of such materials (e.g. brochures, written statements, website, etc.).

**Documentation**

*From NCQA:*

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

*Factors 1–8: NCQA reviews:*

- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
- Patient brochure.
- Letter to the patient/family/caregiver.
- Web materials.
- A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
- A sample record transfer request form.

**Reporting**

Reporting for this Factor is performed by providing the process and materials listed above in the *Policies and Procedures* section. NCQA requests that the practice identify information relevant to this Factor in the documentation.

**Factor 3: The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice**

*From NCQA:*

**Factor 3:** To be an effective medical home, the practice has comprehensive patient information about medications; visits to specialists; medical history; health status; recent test results; self-care information; and data from recent hospitalizations, specialty care or ER visits.

**Policy and Procedures**

The practice is responsible for documenting comprehensive patient information such as medications, referrals, past medical history, health status, recent test results, self-care information, and data from recent hospitalizations and ER visits. Your practice must provide a written policy and procedure for disseminating information and materials addressing the obligations of a medical home, along with examples of such materials (e.g. brochures, written statements, website, etc.).

**SuccessEHS Recommendations**

1. You can use the **Medcin PMH (Past Medical History) template** each time patients present for treatment to capture the patient history.
2. Information recorded on the appropriate PMH Medicine form will display in the Medicine note.

3. Medications prescribed by an outside provider can be recorded in the Medcin module as a Current Medication.

4. Referrals and tests performed outside of the clinic can be documented as a No Bill order. Results can then be attached or documented directly on the order so that they are part of the comprehensive record.

Documentation

From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–8: NCQA reviews:

- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
  - Patient brochure.
  - Letter to the patient/family/caregiver.
  - Web materials.
  - A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
  - A sample record transfer request form.
Reporting

Reporting for this Factor is done by providing the process and materials listed above in the Policies and Procedures section. NCQA requests that the practice identify information relevant to this Factor in the documentation.

Factor 4: The care team provides access to evidence-based care, patient/family education and self-management support

From NCQA:

**Factor 4:** Patients/families/caregivers can expect evidence-based care from their clinician and team, as well as support for self-management of their health and health care, including educational resources and current literature regarding specific health issues.

Policy and Procedure

Your practice must provide a written policy and procedure for disseminating information and materials addressing the obligations of a medical home, along with examples of such materials (e.g. brochures, written statements, website, etc.).

Documentation

From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–8: NCQA reviews:

- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
  - Patient brochure.
  - Letter to the patient/family/caregiver.
  - Web materials.
  - A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
  - A sample record transfer request form.

Reporting

Reporting for this Factor is performed by providing the process and materials listed above in the Policies and Procedures section. NCQA requests that the practice identify information relevant to this Factor in the documentation.
Factor 5: The scope of services available within the practice including how behavioral health needs are addressed

From NCQA:

Factor 5: The practice is concerned with the whole person care, which includes behavioral healthcare. The practice informs patients/families/caregivers how behavioral healthcare needs are met (i.e., by the practice or in coordination with another practice).

Policy and Procedures

The practice is responsible for relaying to patients how behavioral healthcare needs are met (i.e., by the practice or in coordination with another practice). Your practice must provide a written policy and procedure for how this information is given to patients regarding behavioral healthcare needs.

Documentation

From NCQA:

Factor 6: The practice provides equal access to all of their patients regardless of source of payment

From NCQA:

Factor 6: The practice evaluates and meets the needs of patients:

– Considers accepting Medicare/Medicaid/uninsured patients.
– Provides equal access to for all patients accepted into the practice, regardless of insurance status.
Policy and Procedures
The practice is responsible for evaluating and meeting the needs of all patients. Your practice must provide a written policy and procedure for how the practice provides equal access to all patients accepted into the practice, regardless of insurance status.

Documentation
From NCQA:
For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–8: NCQA reviews:
- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
  - Patient brochure.
  - Letter to the patient/family/caregiver.
  - Web materials.
  - A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
  - A sample record transfer request form.

Reporting
Reporting for this Factor is performed by providing the process and materials listed above in the Policies and Procedures section. NCQA requests that the practice identify information relevant to this Factor in the documentation.

Factor 7: The practice gives uninsured patients information about obtaining coverage
From NCQA:

Factor 7: The practice provides information (e.g., brochures, point of contact information) to patients/families/caregivers about potential sources of insurance coverage (e.g., state Medicaid or CHIP [Children’s Health Insurance Program] office), to raise patient awareness of the availability of public health insurance and financial support for care needs.

Policy and Procedures
The practice must provide a written policy and procedure for how the practice provides information to patients/families/caregivers about potential sources of insurance coverage, to raise patient awareness of the availability of public health insurance and financial support for care needs.
Documentation

From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–8: NCQA reviews:

- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
  - Patient brochure.
  - Letter to the patient/family/caregiver.
  - Web materials.
  - A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
  - A sample record transfer request form.

Reporting

Reporting for this Factor is performed by providing the process and materials listed above in the Policies and Procedures section. NCQA requests that the practice identify information relevant to this Factor in the documentation.

**Factor 8: Instructions on transferring records to the practice, including a point of contact at the practice**

From NCQA:

*Factor 8*: The practice guides and helps new patients migrate their personal health record from their former provider, including capturing a point of contact at the transferring practice to help coordinate the transition.

Policies and Procedures

To meet this factor, the practice must create a guide that assists new patients in migrating their personal health record from their former provider to their new provider.

Documentation

From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–8: NCQA reviews:

- A documented process for giving patients information and materials about the role of a medical home.
- Patient materials:
- Patient brochure.
- Letter to the patient/family/caregiver.
- Web materials.
- A written agreement between the patient/family/caregiver and the practice, specifying the role of the medical home, the practice and the patient/family/caregiver (i.e., a patient compact).
- A sample record transfer request form.

**Reporting**

Reporting for this Factor is performed by providing the process and materials listed above in the *Policies and Procedures* section. NCQA requests that the practice identify information relevant to this Factor in the documentation.

**Element 2C: Culturally and Linguistically Appropriate Services**

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessing the diversity of its population.</td>
</tr>
<tr>
<td>2</td>
<td>Assessing the language needs of its population.</td>
</tr>
<tr>
<td>3</td>
<td>Providing interpretation or bilingual services to meet the language needs of its population.</td>
</tr>
<tr>
<td>4</td>
<td>Providing printed materials in the languages of its population.</td>
</tr>
</tbody>
</table>

**VALUE:** 2.5 points

<table>
<thead>
<tr>
<th>SCORING</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors.</td>
<td>The practice meets 3 factors.</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor.</td>
<td>The practice meets no factors.</td>
<td></td>
</tr>
</tbody>
</table>

**Factor 1: Assessing the diversity of its population**

**From NCQA:**

**Factor 1:** The practice uses data to assess the diversity and needs of its population so it can meet those needs adequately. Data may be collected by the practice from all patients directly or may be data about the community served by the practice.

Diversity is a meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved. These characteristics of a group may include, but are not limited to, race, ethnicity, gender identity, sexual orientation and disability.

Note: Patient race and ethnicity are tracked in Element 3A: Clinical Data.
SuccessEHS Recommendations (Factor 1)

Factor 1 requires documentation that racial and ethnic diversity is being assessed.

1. In the Patient Administration module, select the Additional Patient Data tab.

2. Click the **Race...** button in the **Race** field.

3. A **Patient Race** dialog box displays.

4. Click in the **Select** column in the **UDS Approved Races** list to select the appropriate UDS race category. Users may also select a more specific designation by entering the name of the race in the **Additional Races** field (or by clicking to search for and select an additional race from the **Find Additional Races** dialog box).
5. Once the user selects and additional race, they may add it to the patient’s record by clicking the **Select This Additional Race** button. The race will be added to the patient’s record.

6. Select the appropriate **Ethnicity**.

7. Also in Patient Administration on the **Demographics** tab, users can document **Gender** and **Sex** fields for a patient. In our v8.0 update, PAM will also contain a new field to document Sexual Orientation information for the selected patient.

---

**Note** - As defined in the SuccessEHS software, **Sex** is the classification of people as male or female at birth, based on bodily characteristics such as chromosomes, hormones, internal reproductive organs, and genitalia. **Gender** is one’s internal, personal sense of being a man or woman (or a boy or a girl). Gender is used to identify the patient with insurance payers for claims processing purposes.

---

**Documentation**

**From NCQA:**

*Factor 1:* NCQA reviews a report of the practice’s assessment of the diversity (including racial, ethnic and at least one other meaningful characteristic of diversity) and language composition of its patient population.

**Reporting (Factor 1)**

Reporting for this Factor is available via the Success Practice Analytics Report **2C1 – Assessing Diversity-Race_Ethnicity_Gender_Sex.** This report displays the number of patients who have been seen during the selected timeframe along with those who’ve had **Race, Ethnicity, Gender, or Sex** documented. Additional tables that break down each of these elements into their individual values is also available.
Factor 2: Assessing the language needs of its population

From NCQA:

**Factor 2**: The practice uses data to assess the linguistic needs of its population so it can meet those needs adequately. Data may be collected by the practice from all patients directly or may be data about the community served by the practice.

SuccessEHS Recommendations (Factor 2)

Factor 2 requires that the practice assess **Preferred Language** from **Patient Administration**.

1. Preferred Language is documented on the **Additional Patient Data** tab in **Patient Administration**. Staff must use the Additional Patient Data tab to associate the proper Preferred Language.

2. To set the languages up to that best represent your community, contact SuccessEHS Support for the appropriate password.

Documentation

From NCQA:

**Factor 2**: NCQA reviews a report of the practice’s assessment of the diversity (including racial, ethnic and at least one other meaningful characteristic of diversity) and language composition of its patient population.

Reporting (Factor 2)

Reporting for this Factor is available via the Success Practice Analytics Report **2C2 – Language Needs**. This report displays the number of patients who were seen during a selected timeframe and out of those patients, who have had **Language Best Served In** documented. An additional table giving the break-down of the individual languages, number of patients and the percentage is also available.

Factor 3: Providing interpretation or bilingual services to meet the language needs of its population

From NCQA:

**Factor 3**: Language services may include third-party interpretation services or multilingual staff. Under Title VI of the Civil Rights Act, clinicians who receive federal funds are responsible for providing language and communication services to their patients, as required to meet clinical needs.

Asking a friend or family member to interpret for a patient does not meet the intent of this standard. Studies demonstrate that patients are less likely to be forthcoming with a family member present, and the family member may not be familiar with medical terminology. The practice receives credit for this factor if services are available through multilingual staff and contractors, without regard to the level of need in the practice’s population.

To indicate that interpreter services are needed, SuccessEHS suggests a two-step approach that includes using the software and an internal policy and procedure.
Policy and Procedure

It is important that your clinic provide a policy and procedure addressing bilingual services available and how you intend to meet your service to bilingual patients. Please ensure that you provide provisions in your office Policy and Procedure for this process.

SuccessEHS Recommendations

In Patient Administration, you will need to assign the patient to a standard note of Interpreter Needed (if necessary).

1. In Clinical Console, select the System Administration Console from the navigation icon.

![](image1]

2. Select Practice Configuration.

![](image2]


5. Create the Interpreter Needed note by entering the Note Name and any Note Text in the designated areas. Select an Account type of Patient. Select the module(s) you would like this note to “pop up” in once it’s associated to a selected patient and then save the note.

![](image3]

6. Once the note is created, the clinic must associate the standard note to patients needing interpreter services.

7. To do this, access Patient Administration, select the patient, and select the Notes tab.
8. Right click to add a row in the Patient Notes grid. The Patient Notes Entry dialog box displays.

![Patient Notes Entry dialog box]

9. Click in the Note Name field to display the Find Standard Note window.

![Find Standard Note window]

10. Search for the standard note you created in Administration and click OK. You will be returned to the Patient Notes Entry dialog box.

![Patient Notes Entry dialog box]

11. Select OK. The standard note will be associated to the patient. Any module selected will now display this note when the selected patient is chosen.

Documentation

From NCQA:

*Factor 3:* NCQA reviews documentation showing that interpretive services are available at the practice, or has a dated policy or statement that the practice uses bilingual staff. The policy states how the practice helps patients who speak a language that is not spoken by bilingual staff.
Reporting

Reporting for this Factor is accomplished by providing the relevant policy and procedure as defined in the *Policy and Procedure* section above.

**Factor 4: Providing printed materials in the language of its population**

*From NCQA:*

**Factor 4:** The practice identifies languages spoken by at least 5 percent of its patient population and makes materials available in those languages, with regard to patient need (e.g., reading level). For patients with limited proficiency in English, forms that patients are expected to sign, complete or read for administrative or clinical needs are provided in their native language.

Factor 4 is not applicable if the practice provides documentation that no language (other than English) is spoken by 5 percent or more of its patient population.

**SuccessEHS Recommendations**

It is the practice’s responsibility to provide printed patient materials in multiple languages. SuccessEHS uses **ExitCare** for patient education materials, which delivers close to 3,000 individual educational materials available in multiple languages.

Education materials are accessed via the **Pt Ed** icon in the Next Patient ribbon in Clinical Console. Materials are suggested automatically by the system based upon the documented information, including the ICD9 and active procedures/orders for the visit.

Another option is to build Patient Correspondence forms (whether from scratch or scan in a document in another language to be used within Patient Correspondence) to be printed for a given patient.

1. Within **System Administration**, select **Forms > Forms Administration** (please note only certain individuals with appropriate access can build forms).

2. If you prefer to take an existing document and use it as a background image, select **Images:**

![Image of system administration interface showing forms administration menu and images option]
3. Click Add to add a new image. The Image Maintenance dialog box displays.

4. Browse to the location on your computer to access the document and select OK.

5. Select Form Templates and create a new form template.

6. When the form template blank screen loads, select the background image you uploaded in the Properties section (on the right side of the form template screen):

7. The background image will load. If the document is all text for educational purposes, you can name the form and save. Don’t forget to assign the form to users to access it.

8. If you prefer to build a form, simply select the appropriate document type in admin and create a new document using the language of choice. Some restrictions may apply.

**Documentation**

From NCQA:

**Factor 4:** NCQA reviews materials in languages other than English, a screenshot showing system capabilities or a link to online materials or a Web site in languages other than English.

**Reporting**

Reporting for this Factor is accomplished by providing materials or access to materials for patients in languages other than English. Reporting is not necessary if the practice can provide documentation that no single language other than English is spoken by at least 5% of its patient population.
**Note - Please Note:** Factor 2C2 mentions a report that can be used to identify the languages of your patients and the percentage of each language in use that could be helpful in identifying which languages you need to provide such materials in.

## Element 2D: The Practice Team

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Defining roles for clinical and non-clinical team members.</td>
</tr>
<tr>
<td>2</td>
<td>Identifying practice organizational structure and staff leading and sustaining team based care.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Having regular patient care team meetings or a structured communication process focused on individual patient care.</strong>&lt;br&gt;<strong>Note - Factor 3 is a Critical Factor.</strong></td>
</tr>
<tr>
<td>4</td>
<td>Using standing orders for services.</td>
</tr>
<tr>
<td>5</td>
<td>Training and assigning care teams to coordinate care for individual patients.</td>
</tr>
<tr>
<td>6</td>
<td>Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior change.</td>
</tr>
<tr>
<td>7</td>
<td>Training and assigning members of the care team to manage the patient population.</td>
</tr>
<tr>
<td>8</td>
<td>Holding regular team meetings addressing practice functioning.</td>
</tr>
<tr>
<td>9</td>
<td>Involving care team staff in the practice’s performance evaluation and quality improvement activities.</td>
</tr>
<tr>
<td>10</td>
<td>Involving patients/families/caregivers in quality improvement activities or on the practice’s advisory council.</td>
</tr>
</tbody>
</table>

**VALUE:** 4 points

<table>
<thead>
<tr>
<th>SCORING:</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 10 factors (including factor 3).</td>
<td>The practice meets 8-9 factors (including factor 3).</td>
<td>The practice meets 5-7 factors (including factor 3).</td>
<td>The practice meets 2-4 factors.</td>
<td>The practice meets 0-1 factors.</td>
<td></td>
</tr>
</tbody>
</table>
Explanation

MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

Managing patient care is a team effort that involves clinical and nonclinical staff (i.e., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) interacting with patients and working as a team to achieve stated objectives. The clinician leading the team is integral to determining and enacting the processes established by the practice.

The emphasis is on ongoing interactions of team members to discuss roles, responsibilities, communication and patient hand-off, working together to provide and enhance the care provided to patients.

All clinical staff (i.e., physicians, nurse practitioners, behavioral healthcare specialists) are members of the team. Involvement of the patient/family/caregiver with care team members is critically important to patient-centeredness.

This element applies to all types of practices.

When training and assigning roles to care team members, the practice references ongoing measurement activities chosen in PCMH 6, Elements A–C. For example, a team member could lead an effort to conduct outreach and provide updated immunizations to a specific population, which the practice measures in PCMH 6A, factor 1.

Factors 1–10

From NCQA:

Factor 1: Job roles and responsibilities emphasize a team-based approach to care and support each member of the team being trained to meet the highest level of function allowed by state law.

Factor 2: The practice delineates responsibilities for sustaining team-based care, and specifies how care teams align to provide patient-centered care. Specific team units may focus on providing care coordination across and beyond the practice (factor 5). An organizational chart may be used to illustrate how a care team fits in the practice.

Factor 3: Factor 3 is a critical factor and must be met for practices to score higher than 25% on this element.

Team meetings may be informal daily meetings or review daily schedules, with follow-up tasks. A structured communication process may include regular e-mail exchanges, tasks or messages about a patient in the medical record and how the clinician or team leader is engaged in the communication structure.

Factor 4: Standing orders (e.g., testing protocols, defined triggers for prescription orders, medication refills, vaccinations, routine preventive services) may be clinician preapproved or may be executed without prior approval of the clinician, as permitted by state law.

Factor 5: Care coordination may include obtaining test and referral results and communicating with community organizations, health plans, facilities and specialists. Training should accommodate addition of new team members. The practice determines how frequently care team members are trained and retrained.

Factor 6: Care team members are trained in evidence-based approaches to self-management support, such as patient coaching and motivational interviewing.

Training should accommodate addition of new team members. The practice determines how frequently care team members are trained and retrained.
**Facto 7:** Care team members are trained in managing the patient population and addressing needs of patients and families proactively. **Population management** assesses and manages the health needs of a patient population, such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).

Training should accommodate addition of new team members. The practice determines how frequently care team members are trained and retrained.

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

**Facto 8:** The practice holds scheduled team meetings routinely to improve care for all patients (factor 3 addresses care of specific patients). Meetings include clinical staff (e.g., physicians and nurse practitioners) and nonclinical staff. The purpose of these meetings is to discuss practice and staff functions —what is working well and what may need improvement. For example, there could be an ongoing discussion about staff roles and responsibilities, performance measurement data and related quality improvement efforts, team member training and areas for improvement. Meeting frequency can vary (e.g., monthly, bimonthly, quarterly) but are part of the practice’s routine operations.

**Facto 9:** The practice has a documented process for quality improvement activities that includes a description of staff roles and involvement in the performance evaluation and improvement process. The care team receives performance measurement and patient survey data to identify areas and methods for quality improvement. The team may participate in regular quality improvement meetings or in action plan development.

**Facto 10:** The practice has a process for involving patients and their families in its quality improvement efforts. At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team meetings.

**Policies and Procedures**

All ten Factors indicate internal policies and procedures as well as documented job descriptions, responsibilities, training of internal teams, and a documented approach for care-team communication, evaluation, and improvement processes and team meeting minutes.

---

**Note -** Factor 3 is a Critical Factor.

**Documentation**

**From NCQA:**

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.
**Factors 1, 5, 6, 7:** NCQA reviews dated descriptions of staff positions or policies and procedures describing staff roles and functions. The practice may provide an organizational chart or description of the team structure and team members.

**Factor 2:** NCQA reviews an overview of the staffing structure for team-based care.

**Factor 3:** NCQA reviews the practice’s documented process for structured communication between the clinician and other care team members, which states the frequency of communication; and reviews at least three samples of meeting summaries, checklists, appointment notes or chart notes for evidence that the practice follows its process.

**Factor 4:** NCQA reviews at least one example of written standing orders.

**Factors 5–7:** The practice provides a description of its training and training schedule or materials showing how staff has been trained in each area identified in the factors.

**Factor 8:** NCQA reviews a description of team meetings, the frequency of these meetings and at least one example of meeting minutes, agendas or staff memos.

**Factor 9:** NCQA reviews the practice’s documented process for quality improvement.

**Factor 10:** NCQA reviews the organization’s documented process for involving patients/families/caregivers in QI teams or on an advisory council.

**Reporting**

Reporting for these Factors is accomplished by providing the relevant information as noted above.
PCMH Standard 3: Population Health Management

From NCQA:

The Practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

Total point value: 20 points

Element 3E: Implement Evidence-Based Decision Support

The practice implements clinical decision support (e.g. point-of-care reminders) following evidence-based guidelines for:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A mental health or substance use disorder. +</td>
</tr>
</tbody>
</table>

**Note - Factor 1 is a Critical Factor.**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>A chronic medical condition.+</td>
</tr>
<tr>
<td>3</td>
<td>An acute condition.+</td>
</tr>
<tr>
<td>4</td>
<td>A condition related to unhealthy behaviors. +</td>
</tr>
<tr>
<td>5</td>
<td>Well child or adult care. +</td>
</tr>
<tr>
<td>6</td>
<td>Overuse/appropriateness issues. +</td>
</tr>
</tbody>
</table>

+Stage 2 Meaningful Use Requirement

**VALUE:** 4 points

**SCORING:**

<table>
<thead>
<tr>
<th>%</th>
<th>The practice meets 5-6 factors (including factor 1).</th>
<th>The practice meets 4 factors (including factor 1).</th>
<th>The practice meets 3 factors.</th>
<th>The practice meets 1-2 factors.</th>
<th>The practice meets 0 factors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<tr>
<td>0%</td>
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</tr>
</tbody>
</table>

**Explanation**

**Factor 1 is a critical factor and must be met for practices to receive a 75% or 100% score.**

The practice maintains continuous relationships with patients through care management processes based on evidence-based guidelines. A key to successful implementation of guidelines is to embed them in the practice’s day-to-day operations (frequently referred to as “clinical decision support”) and use registries that identify and engage patients in need of important services proactively (as in PCMH 3, Element D). Clinical data collected in
PCMH 3, Element B supports the practice’s approach to meeting criteria in this element. When selecting conditions, the practice considers:

- Diagnoses and risk factors prevalent in patients seen by the practice.
- The availability of evidence-based clinical guidelines.
  - American Board of Internal Medicine Foundation’s Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (www.choosingwisely.org).
  - Other resources for evidence-based guidelines include:
    - Up-to-Date: www.uptodate.com

Factor 1: A mental health or substance use disorder

Note - Factor 1 is a Critical Factor.

From NCQA:

**Factor 1:** The practice has evidence-based guidelines it uses for clinical decision support related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer’s) or substance abuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism).

Factor 2: A chronic medical condition

From NCQA:

**Factor 2:** The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition. Relevant chronic conditions may include, but are not limited to, arthritis, asthma, cardiovascular disease, COPD, diabetes and eczema.

Well-child care is not an acceptable chronic condition for this factor.

Factor 3: An acute condition

From NCQA:

**Factor 3:** The practice has evidence-based guidelines it uses for clinical decision support related to at least one acute medical condition. Relevant acute conditions may include, but are not limited to, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis and urinary tract infection.

Factor 4: A condition related to unhealthy behaviors

From NCQA:

**Factor 4:** The practice has evidence-based guidelines it uses for clinical decision support related to at least one unhealthy behavior (e.g., obesity, smoking).
Factor 5: Well child or adult care

From NCQA:

Factor 5: The practice has evidence-based guidelines it uses for clinical decision support related to well-child or adult care (e.g. age appropriate screenings, immunizations).

Factor 6: Overuse/appropriateness issues

From NCQA:

Factor 6: The practice has evidence-based guidelines it uses for clinical decision support related to overuse or appropriateness of care issues (e.g. use of antibiotics, avoiding unnecessary testing, and referrals to multiple specialists).

SuccessEHS Recommendations

Step 1: Determine the following for your clinic:

1. What is a mental health or substance use disorder relevant to your patient population?
2. What is a chronic medical condition relevant to your patient population?
3. What is an acute condition relevant to your patient population?
4. What is a condition related to unhealthy behaviors relevant to your patient population?
5. What immunizations, screenings, etc. for well-child or adult care are the most relevant to your patient population?
6. What overuse/appropriateness of care most applies to your practice and patient population?

This should be done by analyzing your patient population to determine diagnoses and risk factors that are prevalent in your patient population. Tools such as Success Practice Analytics and Clinical Event Manager can be used to make these determinations. At least one condition must be associated to unhealthy behaviors, substance abuse, or a mental health issue.

Step 2: Implement evidence-based guidelines for your chosen conditions. You can use the Clinical Event Manager to configure rules based on the information in your patient's records. Clinical Event Manager allows you to configure rules based on ICDs, CPTs, Lab Test Results, and Medcin findings, among other things. For more information on how to configure Clinical Event Manager rules, please refer to available Clinical Event Manager classes available through our customer portal.

Once Clinical Event Manager rules are in place, clinical users will be alerted in the following ways:

- **Patient Alerts**
  The Patient Alert icon is available on the Next Patient and Documentation ribbon. This icon will display the Clinical Event Manager rules applicable to the patient. Patient Alerts tab in Chart is also accessible in v7.40 and above.
- Indicates that no patient alert information exists for the patient

- Indicates that patient alert information does exist for the patient

**Clinical Decision Support**

Clinical Decision Alerts are point of care reminders that can be enabled for Clinical Event Manager Rules. To designate a CEM rule as Clinical Decision Support, select the checkbox in the **Rule Maintenance** field.

**CDS Preferences**

To determine when you will receive Clinical Decision Support Alerts, you first must set your User Preferences.
1. In **User Preferences**, select the + next to **Compliance Configuration**.

2. In the **Clinical Decision Alert Preferences**, select **Check and Prompt for Clinical Decision Support**.

3. Once the Check and Prompt for Clinical Decision Support box is checked, users will be able to activate CDS alert prompts when performing certain actions. The following actions will be available for prompting CDS alerts:
   - **Clinical Console** – Open Chart Overview, Open Medcin (concise view), Quick Close, Close Code Selector, Close Encounter Detail, Close Vitals
   - **Superbill** – Open Superbill, View Visit Summary Tab, Submit ESB
   - **Medications** – Open Medications (Summary Screen), Close Medications
   - **Order Detail** – Open Order Details, Apply/ Save & Exit
   - **Transition of Care Reconciliation** – Close Med/ Allergy Reconciliation, Close Problem Reconciliation

**Note** - Whenever a user performs any of the above enabled actions in Clinical Console, CEM will run for the patient.

4. Users may select (check) one or more rules to receive prompts for during the reporting period. (At least one rule must be selected).

5. Users may select (check) **Auto select new rules added to the list** to automatically add and enable any newly created CDS rules.

**Viewing CDS Alerts**

After selecting a patient, users may click the CDS button to display a pop-up window and view any CDS alerts associated with the patient on the CDS tab.

- If no CDS alerts exist for the selected patient, a **No Alerts Exist** message will display in the **Rule Description** column on the **CDS** tab.
– If CDS alerts exist, but the user has been set up not to view them, a No Alerts Exist for: Username message will display in the Rule Description column.

– If CDS alerts exist that the user has been set up to view, the CDS button label will display an asterisk (i.e., CDS*).

– CDS rules will display in red text the first time a user views them and in black text for all subsequent viewings. Users may click the button for each rule to display an information bubble with details for the rule.

Users may re-run CDS rules for any patient in the pop-up window by selecting the patient and click Run CDS Rules button. A Checking CDS Alerts message will display. New rules will display in the Rule Description column once the check has been completed.

Users may also click the Chart Overview button by any patient name to launch Chart Overview for the specific patient. Once Clinical Console is closed, all patients will be cleared from the CDS tab.
Step 3: Provide examples of the guidelines implementation. This can be accomplished through the use of Flowsheets, Medcin forms, Patient Correspondence documents or other condition-specific guidelines that enable the practice to develop treatment plans and document patient status and progress. These tools should be used by the practice to manage patient care.

To assist you in documenting patient education, patient goals and patient progress, PCMH Medcin forms have been developed and provided to you along with the toolkit. Patient Correspondence forms have also been developed to assist in providing Care Plans and Self-Management tools. More information on the tools provided to assist with PCMH Standards 3 and PCMH Standard 4, Element A are included in the Overview section of this toolkit.

Documentation

From NCQA:

Factors 1–6: NCQA reviews:

- The conditions that the practice identified for each factor.
- The source of guidelines used by the practice, for each condition.

Examples of guideline implementation, such as tools to manage patient care, organizers, flow sheets or electronic system organizer (e.g. registry, EHR, or other system) templates based on condition-specific guidelines, enabling the practice to develop treatment plans and document patient status and progress.

Reporting

Reporting for this Factor will be accomplished by providing the data described above in the Documentation section.
PCMH Standard 4: Care Management and Support

From NCQA:

The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

Total point value: 20 points

Element 4A: Identify Patients for Care Management

The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Behavioral health conditions.</td>
</tr>
<tr>
<td>2</td>
<td>High cost/high utilization.</td>
</tr>
<tr>
<td>3</td>
<td>Poorly controlled or complex conditions.</td>
</tr>
<tr>
<td>4</td>
<td>Social determinants of health.</td>
</tr>
<tr>
<td>5</td>
<td>Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.</td>
</tr>
<tr>
<td>6</td>
<td>The practice monitors the percentage of the total patient population identified through its process and criteria.</td>
</tr>
</tbody>
</table>

**Note** - Factor 6 is a Critical Factor.

VALUE: 4 points

<table>
<thead>
<tr>
<th>SCORING:</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 5-6 factors (including factor 6).</td>
<td>The practice meets 4 factors (including factor 6).</td>
<td>The practice meets 3 factors (including factor 6).</td>
<td>The practice meets 2 factors (including factor 6).</td>
<td>The practice meets 0-1 factors (or does not meet factor 6).</td>
<td></td>
</tr>
</tbody>
</table>

Explanation

The intent of the element is that practices use defined criteria to identify true vulnerability—a single criterion, such as cost, may not be an appropriate indicator of need for care management.

**Factor 6 is a critical factor and is required for practices to receive a score above 0% on this element.**
Although patients can be identified for care management by diagnosis or condition, the emphasis of care must be on the whole person over time and on managing all of the patient’s care needs. The practice adopts evidence-based guidelines and uses them to plan and manage patient care.

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

The practice considers how its comprehensive health assessment (PCMH 3, Element C) supports establishing criteria and a systematic process for identifying patients for care management.

The practice receives credit for each factors (1–5) included in its criteria for identification of patients for care management. A patient may fall into more than one category (factor) and may be included in some or all of these counts. The practice uses criteria to create a registry of patients identified as likely to benefit from care management. There may be more than one set of processes and criteria to identify specific types of patients.

**Factor 1: Behavioral health conditions**

**From NCQA:**

**Factor 1:** The practice has specific criteria for identifying patients with behavioral conditions for whole-person care planning and management.

Criteria are developed from a profile of patient assessments, and may include the following, or a combination of the following:

- A diagnosis of a behavioral issue (e.g., visits, medication, treatment or other measures related to behavioral health).
- Psychiatric hospitalizations (e.g., two or more in the past year).
- Substance use treatment.
- A positive screening result from a standardized behavioral health screener (including substance use).

**Pediatric populations**

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

**Policy and Procedure**

Each practice must define their own policy and procedure regarding identifying patients with Behavioral Health conditions.

**SuccessEHS Recommendations**

The SuccessEHS software implements care management in the Clinical Event Manager (CEM). CEM can be used to build rules to identify patients needing care management. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.

If no one in your clinic is proficient in the building and running of CEM rules, please contact SuccessEHS support at 877-866-4347 or helpdesk@ehsmed.com to sign up for a training class.
Documentation

From NCQA:

**Factor 1:** NCQA reviews the practice’s documented process that describes the criteria for identifying patients for each factor.

**Reporting**

Reporting for this Factor is done by providing a copy of the practice’s process for identifying patients with Behavioral Health conditions.

**Factor 2: High cost/high utilization**

From NCQA:

**Factor 2:** The practice has specific criteria for identifying patients who experience high utilization or high cost. The practice may consider the following when establishing criteria:

- ER visits.
- Hospital readmissions.
- Unusually high numbers of imaging or lab tests ordered.
- Unusually high number of prescriptions.
- High-cost medications.
- Number of secondary specialist referrals.
- Reports, alerts or other notifications from health plans indicating high cost or high utilization.

**Policy and Procedure**

Each practice must define their own policy and procedure regarding identifying patients with high cost/high utilization.

**SuccessEHS Recommendations**

The SuccessEHS software implements care management in the **Clinical Event Manager (CEM)**. CEM can be used to build rules to identify patients needing care management. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.
If no one in your clinic is proficient in the building and running of CEM rules, please contact Greenway Support to sign up for a training class.

Documentation

From NCQA:

**Factor 2:** NCQA reviews the practice’s documented process that describes the criteria for identifying patients for each factor.

**Reporting**

Reporting for this Factor is done by providing a copy of the practice’s process for identifying patients that endure high costs/high utilizations.

**Factor 3: Poorly controlled or complex conditions**

From NCQA:

**Factor 3:** The information and process for identifying high-cost/utilization patients may differ from the process for identifying poorly controlled patients (e.g., with continued abnormally high A1C or blood pressure results). Patients who consistently fail to meet treatment goals or with multiple comorbid conditions may be included in the criteria for this factor.

**Policy and Procedure**

Each practice must define their own policy and procedure regarding identifying patients with poorly controlled or complex conditions.

**SuccessEHS Recommendations**

The SuccessEHS software implements care management in the Clinical Event Manager (CEM). CEM can be used to build rules to identify patients needing care management. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.

If no one in your clinic is proficient in the building and running of CEM rules, please contact Greenway Support to sign up for a training class.
Documentation

From NCQA:

**Factor 3**: NCQA reviews the practice’s documented process that describes the criteria for identifying patients for each factor.

Reporting

Reporting for this Factor is done by providing a copy of the practice’s process for identifying patients that have poorly controlled or complex conditions.

**Factor 4: Social determinants of health**

From NCQA:

**Factor 4**: The practice has a process for identifying patients based on social determinants of health. Social determinants of health are conditions in the environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include: availability of resources to meet daily needs; access to educational; economic and job opportunities; public safety, social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation and others (Healthy People 2020).

Policy and Procedure

Each practice must define their own policy and procedure regarding identifying patients with social determinants of health.

SuccessEHS Recommendations

The SuccessEHS software implements care management in the Clinical Event Manager (CEM). CEM can be used to build rules to identify patients needing care management. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.

If no one in your clinic is proficient in the building and running of CEM rules, please contact SuccessEHS support at 877-866-4347 or helpdesk@ehsmed.com to sign up for a training class.
Documentation

From NCQA:

**Factor 4**: NCQA reviews the practice’s documented process that describes the criteria for identifying patients for each factor.

**Reporting**

Reporting for this Factor is done by providing a copy of the practice’s process for identifying patients that social determinants of health.

**Factor 5: Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver**

From NCQA:

**Factor 5**: The practice has a process based on these criteria that is intended to allow for referrals by external entities and nominations by those closest to patients/families/caregivers.

**Policy and Procedure**

Each practice must define their own policy and procedure regarding identifying patients referred by external entities.

**SuccessEHS Recommendations**

The SuccessEHS software implements care management in the **Clinical Event Manager (CEM)**. CEM can be used to build rules to identify patients needing care management. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.

If no one in your clinic is proficient in the building and running of CEM rules, please contact Greenway Support to sign up for a training class.
From NCQA:

**Factor 5:** NCQA reviews the practice’s documented process that describes the criteria for identifying patients for each factor.

**Reporting**

Reporting for this Factor is done by providing a copy of the practice’s process for identifying patients that are referred by external entities.

**Factor 6: The practice monitors the percentage of the total patient population identified through its process and criteria**

Note - **Factor 6 is a Critical Factor.**

From NCQA:

**Factor 6:** Assessment of a combination of factors 1–5 results in a subset of the practice’s entire panel of patients identified as likely to benefit from care management.

Note: Patients identified in this element will be used to draw a sample for the medical record review required in PCMH 4, Elements B and C.

**Documentation**

From NCQA:

**Factor 6:** NCQA reviews a report showing the number and percentage of its total patient population identified as likely to benefit from care management.

The practice calculates a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage:

- Denominator = Total number of patients in the practice.
- Numerator = Number of unique patients identified in the denominator as likely to benefit from care management by the criteria in factors 1–5.
Reporting

Reporting for this Factor is done through the Success Practice Analytics Report 4A6 – Patient Population Monitored. This report takes into consideration factors 1 – 5 and all patients pulled into the corresponding CEM rules. A prompt for the CEM Rules you have set up for factors 1 – 5 is available when you generate the report.

- **Denominator:** Total Patient Population
- **Numerator:** Number of patients in the denominator that pull in CEM rule(s) from 4A1 – 4A5

Element 4C: Medications Management

The practice has a process for managing medications, and systematically implements the process in the following ways:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reviews and reconciles medications with patients/families for more than 50% of care transitions.+</td>
</tr>
<tr>
<td></td>
<td>Note - Factor 1 is a Critical Factor.</td>
</tr>
<tr>
<td>2</td>
<td>Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.</td>
</tr>
<tr>
<td>3</td>
<td>Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.</td>
</tr>
<tr>
<td>4</td>
<td>Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.</td>
</tr>
<tr>
<td>5</td>
<td>Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.</td>
</tr>
<tr>
<td>6</td>
<td>Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.</td>
</tr>
</tbody>
</table>

+ Stage 2 Meaningful Use Requirement

<table>
<thead>
<tr>
<th>VALUE:</th>
<th>4 points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCORING:</strong></td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>The practice meets 5-6 factors (including factor 1).</td>
<td>The practice meets 3-4 factors (including factor 1).</td>
</tr>
</tbody>
</table>
Factor 1: Reviews and reconciles medications for more than 50 percent of patients received from care transitions

AND

Factor 2: Reviews and reconciles medications with patients/families for more than 80 percent of care transitions

From NCQA:

Factors 1 & 2: Assessment of this element is based on a sample of the patients identified in Element A. The same patients are used for the medical record review in PCMH 3, Element C and PCMH 4, Elements B and C.

Factors 1, 2: Factor 1 is a critical factor and is required for practices to receive a score on this element.

The practice reviews and documents in the medical record all prescribed medications the patient is taking. Medication review and reconciliation occurs, at least annually, at transitions of care and at relevant visits. The practice may use its own criteria to determine a relevant visit.

Maintaining a list of current medications and resolving medication conflicts reduces the possibility of duplicate medications, medication errors and adverse drug events. A process for reconciling medications is essential for patient safety.

Note - Factor 1 is a Critical Factor.

Factor 1 aligns with Meaningful Use Stage 2 Core Measure: Medication Reconciliation. Reference the Meaningful Use Toolkit for more information on documenting an inbound transition of care and reconciling medications, if needed. The following illustrates the process for appropriately adding current medications and documenting that you have reconciled the medications list.

SuccessEHS Recommendations

STEP ONE: DOCUMENT AN INBOUND TRANSITION IN CARE

Option 1: eSuperbill or Code Selector

Inbound transitions of care can be added from eSuperbill or Code Selector. Referral sources can be configured to be defaulted as outbound or inbound. Users may also make this distinction on-the-fly from the Order Detail window or the Advanced Add tab within Code Selector.

eSuperbill
Order Detail

Code Selector

Option 2: Check-In

1. From the **Check-In** window, select **...** in the **Referral Source** box.

2. The **Find Referral Source** window displays. Search for the appropriate referral source, select their name and click **OK**.

3. Select (check) the box next to the **Referral Source** name.
4. Click Save.

Adding a New Inbound Referral Source

- You may add a new referral to the referral table (to display in the Name drop-down list) by clicking the Add to Referral Table button. A Referral Detail window will display for you to input the appropriate information.) Select Inbound and Transition of Care in the Type drop-down lists in the Referral Configuration section.

- Enter the appropriate Transfer/Referral Reason.
- Click Apply to save your changes and keep the window open, or Save to save your changes and close the window.

STEP TWO: REVIEW AND UPDATE THE MEDICATIONS LIST

For all patients seen during the reporting period, document (or update) the medications the patient is taking using the structured drug database. If the patient is not taking any medications, document No Known Current Meds. Once completed, document that the medications list has been reconciled by selecting the Medications Reconciled button.
Compliance Configurations for Medications/Allergies can be configured to assist in meeting compliance with this measure.

Clinical Console > System Administration > Clinic Configuration > Compliance Configuration

1. **Medications/Allergies:** Configure the prompt on the Medications Summary tab in Medications, where the No Known Current Meds checkbox is not selected (checked).
   - **Prompt upon ESBill submit if medications summary is empty and No Known Current Meds is unchecked:** Select (check) this checkbox to trigger a prompt if, when submitting an eSuperbill, the patient has no current medications documented on the Medications Summary tab in Medications, and the No Known Current Med checkbox is not selected (checked).

2. **Transition/Referral:** Configure the transition of care for reconciled medications as follows.
   - **Prompt user on ESBill submit when an Inbound transition exists and Medication Reconciliation was not documented:** Select (check) this checkbox to trigger a prompt if, when submitting an eSuperbill, an inbound transition of care or referral exists for the patient that has not had medications reconciled via the Medication Reconciliation button in Medications.
   - **Prompt user at encounter signoff when an inbound transition exists and Medication Reconciliation was not documented:** Select (check) this checkbox to trigger a prompt if, when signing off a chart encounter, an inbound transition of care or referral exists for the patient that has not had medications reconciled via the Medication Reconciliation button in Medications.

**Reporting**

Reporting for Factor 1 is available via the Success Practice Analytics Report 4C1 – Med Reconciled. This same report should be used for 4C2 if percentage exceeds 80%. Data in this report is calculated according to the following formula:

- **Denominator:** Patient population from the CEM rule(s) selected by the user identified as likely to benefit from care management who’ve had a relevant visit during the selected timeframe AND an inbound transition of care
- **Numerator:** Number of those patients in the denominator whose medications were reviewed and reconciled during the selected timeframe
Factor 3: Provides information about new prescriptions to more than 80 percent of patients/families/caregivers

From NCQA:

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

Factor 3 aligns with Meaningful Use Stage 2: Patient Education.

SuccessEHS Recommendations

Option 1: Drug Information

Select the Drug Info button for a medication in the Medications window, Add Medications dialog box, or Advanced Add Medications dialog box, then print the information provided on the Patient Education tab.

Option 2: Medcin

Medcin findings can be used to document that the patient was counseled on instructions for use, side effects and/or general information regarding new prescriptions. The following Medcin findings are included on the PCMH Medcin Forms:

- 196999 – Patient Education: Medications
- 197095 – Patient Education- Proper use of Medications
- 78562 – Parent Education: Medication Use
- 78715 – Medication Admin and Compliance

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report 4C3 – New Prescription Info. Data in this report is calculated according to the following formula:

- **Denominator**: Patient population from the CEM rule(s) selected by the user identified as likely to benefit from care management who’ve had a relevant visit during the selected timeframe and a new medication prescribed
- **Numerator**: Number of those patients in the denominator who had drug info printed or one of the listed Medcin findings documented
Factor 4: Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment

From NCQA:

**Factor 4:** The practice assesses how well patients understand the information about medications they are taking, and considers a patient’s health literacy (PCMH 3, Element C, factor 10).

SuccessEHS Recommendations

Medcin may be used to document patient/family understanding of medications information. To document that you have assessed the patient's understanding of medication information, document finding **1001293: Assessed patient/family understanding of medications**.

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report **4C4 – Assess Understanding of Meds**. Data in this report is calculated according to the following formula:

- **Denominator:** Patient population from the CEM rule(s) selected by the user identified as likely to benefit from care management who’ve had a relevant visit during the selected timeframe and a medication prescribed during the selected timeframe
- **Numerator:** Number of those patients in the denominator who had finding **1001293: Assessed patient/family understanding of medications** documented

Factor 5: Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment

From NCQA:

**Factor 5:** The practice asks patients about a problem or difficulty taking a medication; whether they are experiencing side effects; and whether the medication is being taken as prescribed. If a patient is not taking a medication as prescribed, the practice determines why.

SuccessEHS Recommendations

Medcin may be used to document that you have assessed patient’s response to medications and barriers to adherence. To document that you have assessed the patient's response to medications and barriers to adherence, document finding **1001294: Assessed patient response to medications and barriers to adherence**.

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report **4C5 – Assess Response to Meds**. Data in this report is calculated according to the following formula:

- **Denominator:** Patient population from the CEM rule(s) selected by the user identified as likely to benefit from care management who’ve had a relevant visit during the selected timeframe and a medication prescribed during the selected timeframe
- **Numerator:** Number of those patients in the denominator who had finding **1001294: Assessed patient response to medications and barriers to adherence** documented
Factor 6: Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates

From NCQA:

Factor 6: At least annually, the practice reviews and documents in the medical record, over-the-counter (OTC) medications, herbal therapies and supplements, to prevent interference with prescribed medication and to evaluate potential side effects.

SuccessEHS Recommendations

If the provider recommends an OTC medication for a patient, document this using the Add button in the Medications module to add it to the patient's medications list.

If a patient is taking OTC medications that were not prescribed within the clinic, document those in the Medications module by selecting the Current button and choosing the appropriate medications.

The OTC column in the Active Meds and Inactive Meds Hx tabs in the main Medications window, and the OTC Medication checkbox on the Med Details tab in the Add Medications window, display a checkmark for all over-the-counter medications.
Documentation

From NCQA:

Factors 1–6: NCQA reviews reports from the practice’s electronic system OR the Record Review Workbook. If using the Record Review Workbook examples are required demonstrating how each factor is documented.

The practice calculates a percentage that requires a numerator and a denominator, using one of the following methods.

Method 1: Query the practice’s electronic registry, practice management system or other electronic systems for the patients identified in Element A. This method is used if the practice can determine a denominator, as described below.

- Denominator = Total number of patients identified through the criteria in Element A seen at least once for a relevant visit by the practice in a recent three-month period.
- Numerator = Number of patients identified in the denominator for whom each item is entered in the medical record.

Method 2: Use the instructions in the Record Review Worksheet to choose a sample of relevant patients and check for the relevant items. For each factor to which the practice responds “yes,” it provides an example of how it meets the factor.

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

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report 4C6 – OTC Drugs. Data in the report is calculated according to the following formula:

- **Denominator:** Patient population from the CEM rule(s) selected by the user identified as likely to benefit from care management who’ve had a relevant visit during the selected timeframe
- **Numerator:** Patients with OTC drug prescribed or if no OTC meds, medications were reconciled
### PCMH Standard 5: Care Coordination and Care Transitions

From NCQA:

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

**Total score available: 18 Points**

**Element 5A: Test Tracking and Follow-Up**

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tracks lab tests until results are available, flagging and following up on overdue results. <strong>Note - Factor 1 is a Critical Factor.</strong></td>
</tr>
<tr>
<td>2</td>
<td>Tracks imaging tests until results are available, flagging and following up on overdue results. <strong>Note - Factor 2 is a Critical Factor.</strong></td>
</tr>
<tr>
<td>3</td>
<td>Flags abnormal lab results, bringing them to the attention of the clinician.</td>
</tr>
<tr>
<td>4</td>
<td>Flags abnormal imaging results, bringing them to the attention of the clinician.</td>
</tr>
<tr>
<td>5</td>
<td>Notifies patients/families of normal and abnormal lab and imaging test results.</td>
</tr>
<tr>
<td>6</td>
<td>Follows up with inpatient facilities on newborn hearing and blood-spot screening (NA for adults).</td>
</tr>
<tr>
<td>7</td>
<td>More than 30 percent of laboratory orders are electronically recorded in the patient record. +</td>
</tr>
<tr>
<td>8</td>
<td>More than 30 percent of radiology orders are electronically recorded in the patient record. +</td>
</tr>
<tr>
<td>9</td>
<td>Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.</td>
</tr>
<tr>
<td>10</td>
<td>More than 10 percent of scans and tests that result in an image are accessible electronically.</td>
</tr>
</tbody>
</table>

**VALUE:** 6 points

<table>
<thead>
<tr>
<th>VALUE</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCORING:</strong></td>
<td>The practice meets 8-10 factors including Factors 1 and 2.</td>
<td>The practice meets 6-7 factors, including Factors 1 and 2.</td>
<td>The Practice meets 4-5 factors including Factors 1 and 2.</td>
<td>The practice meets 3 factors, including Factors 1 and 2.</td>
<td>The Practice meets 0-2 factors, or does not meet Factor 1 and 2.</td>
</tr>
</tbody>
</table>
Explanation:
Systematic monitoring helps ensure that needed tests are performed and results are acted on, when necessary.

**Factor 1: Track lab tests until results are available, flagging and following up on overdue results**
AND

**Factor 2: Track imaging results until results are available, flagging and following up on overdue results**

From NCQA:

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

**Note** - **Factors 1 and 2 are Critical Factors.**

**Policy and Procedure**

In addition to the use of the software, it is important that your clinic establish and maintain current policies and procedures to proactively track and follow up on orders appropriately. Once your clinic has determined these policies and procedures, the providers' various order lists should be monitored and worked accordingly. This process must be documented by your practice.

**SuccessEHS Recommendations**

Factors 1 and 2 require both the use of order entry and the use of delinquent orders management. Following up by reviewing and signing off all resulted orders is critical in maintaining complete medical records. The following workflow addresses pending and delinquent orders and outlines how to manage these in your practice.

**WORKFLOW RECOMMENDATIONS**

**Order Entry & Management** is a strength of the SuccessEHS software. This functionality replaces stacks of charts and papers cluttering providers’ desks. For this factor, we recommend that orders be set up with appropriate delinquent dates so that the order flows to the provider’s Delinquent Orders Without Results list, where the orders can be easily tracked and followed up on. Orders should be tracked from the time they are ordered until results are received.

**Pending Results** allows your clinic to track labs, radiology tests, etc. until the results are available. Orders that need results reside in the Pending Results list. Labs, radiology tests, and consults are the most common examples. If an order does not require results then it should be documented as Results Not Required in Clinical
Management Console so it does not flow to this list upon ordering.

To track pending results:

1. Select the Provider Organizer in Clinical Console.
2. Select the Provider.
3. Select Pending Results.
4. Sort the list by patient name or date.
5. Select the order.
6. Click the Details icon for the selected order you wish to result or for which you wish to include any additional order comments (i.e., consult appt date/time) order and enter date performed.
7. Enter the result comments, result observation values, and/or scanned documentation or attachments to be included.
8. Click the Save icon in the menu ribbon and move to the next order in the Pending Results list to be updated.

A Delinquent Order is an active order that has attached to it a timeline during which it is believed the result should have been entered in the system and has not been. For example, an X-ray order could be an active delinquent order if, after 4 days, we still have not entered the result in the system and the original delinquent date was set to 48 hours.

To enter a delinquent after time for an order:

1. Open Clinical Console and navigate to the System Administration mode.
2. Choose the Clinic Configuration tab if it is not already chosen.
3. Open your Starter Set.

4. Choose the appropriate order type where your order can be found.

5. Select the Edit icon to open the details screen for the order.

6. Document the time frame in which you expect results within the Delinquent After fields.

7. Once the time frame documented on the order in CMC has passed, that order becomes delinquent and begins displaying in purple. Delinquent orders will still be found in the Pending Results list, but they will also be found in the Delinquent Orders Without Results list. The Delinquent Orders without Results list provides the provider with a single screen to view all delinquent orders for their patients and quickly follow up on them to obtain results. This list should be proactively monitored and worked according to practice policy.

Documentation

From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–6: NCQA reviews:

– A documented process, and
– Evidence showing how the process is met for each factor such as a report or a log or examples (to receive credit for the factor the practice must show evidence across patients not just a single example).
Reporting

Reporting for both Factors is accomplished by providing the relevant policy and procedure as defined in the Policy and Procedure section above, along with a report or log including at least one (1) week of data and an example of how the policy/procedure is met by the clinic. A log can include screenshots from Orders Management, including Pending Results and Delinquent Orders without Results Task List.

Within the Clinical Console Process Reports menu, you can also use the Pending Results report to help with reporting. The report allows you to print for a specific provider or date range.

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

From NCQA:

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

Note - Factors 3 and 4 are complementary to Factors 1 and 2, in that they are directly related to the communication of results tracked in Factors 1 and 2.

Policy and Procedure

These Factors require that the clinic have a written process for staff to follow to flag abnormal results for lab and imaging tests to providers.

SuccessEHS Recommendations

For this Factor, it is recommended that labs are marked with the appropriate indicator when abnormal results are received. In addition, both labs and imaging results can be flagged to the appropriate user for review when abnormal results are received. Follow the workflows described below to configure, result, and flag orders appropriately.

Path/labs that receive a quantitative result can be configured with a range so that they are automatically marked as abnormal when out of range results are entered. Labs that do not receive quantitative results can have the appropriate indicator chosen to produce the same result.
To set up your labs with components so you can indicate when they are abnormal follow the steps below.

1. Go to System Administration mode in Clinical Console and select the plus sign (+) next to the words Starter Set.
2. Select Path/Labs and identify the orders that need to be set up with components.
3. Select the Results column for the order that you are setting up.
4. Open the Edit Component Details screen for the components associated to the order by double clicking the component(s) under the Selected Components section located on the right side of the screen.
5. Continue with step 1 under the "Setting Up Your Result Components" section below.

SETTING UP YOUR RESULT COMPONENTS

Coded Text
1. Select Coded Text from the Result type drop down menu.
   The data box at the bottom will become active and you can check any of the items listed as possible answers.
2. If the desired codes text is not present in the list of choices, you can add it by selecting the Edit Coded Text button in the ribbon of this window.
3. Click on the green plus sign to add a choice. It is important that you type in the Code – the description is optional.
4. Continue until you have added all the choices you need.
5. Save and exit.
6. Select your newly added choices from the list to associate them to the result component.
7. Save and exit.

Quantitative
1. Select Quantitative from the Result type drop down menu.
2. Units is now a required field. If there is not a unit for this component, you will need to select the empty space.
3. If the appropriate unit is not present in the list of choices, you can add choices.
4. Click on the Edit Unit button in the ribbon of this window.
5. Click on the green plus sign to add a choice.
6. Continue until you have added all the choices you need.
7. Save and Exit.
8. You will have to go check anything added; additions will not automatically be checked.
9. Enter a low and high range for normal results,
10. Save and Exit.

RESULTING A PATH/LAB WITH ABNORMAL RESULTS
1. Open the Order Detail screen.
2. Enter results for all components that you have results for.
3. If the results are quantitative results that have been set up with the proper range, then the indicator column will automatically switch to H (High), L (Low), or N (Normal) depending on what result is entered.

4. If the result is not quantitative or has not been set up with the appropriate range, then select the appropriate indicator from the Indicator combo box.

5. Once a lab has been given an abnormal indicator (anything except for N) they will automatically display in red within Clinical Console, and in the provider’s Orders To Sign Off list. If you are set up with a lab interface, then these indicators are typically sent along with the lab results.

The following workflow outlines how to flag labs and imaging tests with abnormal results for review.

**FLAGGING AN ITEM FROM A TASK LIST**

Flags can be used to alert users of abnormal results. A flag placed on an item becomes a permanent part of the patient’s medical record. You can print various reports from Clinical Console that include information about flags.

1. Click the desired row in the appropriate task list and click . The Flag dialog box displays.

2. Click in the Route To box to select who the flag will be sent to. Only users with Security access to Chart or Organizer can be selected.

3. Click in the Priority box to select the flag’s priority level.

4. Enter any Comments associated with the flag.

5. Enter the date range that the flag will be active.
6. Click 🎯 to save the changes and leave the **Flag** dialog box open.
   — or —
   Click 🎯 to save the changes and close the **Flag** dialog box.
   — or —
   Click **Reply** to reply to the user who last sent the flag and change the **From** user to the user who is replying to the flag.
   — or —
   Click **Reply & Save** to perform the same actions as the **Reply** button, and also save the flag.

7. To access the flag report in the patient’s chart, select **Flag Overview** from the **Flags** menu ribbon.

**Documentation**

**From NCQA:**

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

**Factors 1–6:** NCQA reviews:

- A documented process and
- Evidence showing how the process is met for each factor such as a report or a log or examples (to receive credit for the factor the practice must show evidence across patients not just a single example).

**Reporting**

Reporting for this Factor is accomplished by providing the relevant policy and procedure as defined in the **Policy and Procedure** section above, along with a report or log including at least one (1) week of data and an example of how the policy/procedure is met by the clinic.

A log can include screenshots of Orders to Sign Off or Flag Task List for a specific user.

**Factor 5: Notifies patients/families of normal and abnormal lab and imaging test results**

**From NCQA:**

**Factor 5:** The practice is proactive in notifying patients about test results (normal and abnormal). Filing the report in the medical record for discussion during a scheduled office visit does not meet the requirement.

If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations of follow-up results and a plan for handling abnormal results.

**Policy and Procedure**

It is important that your clinic maintains a current policy and procedure on what your practice determines as "timely" notification of lab and radiology results. Once your clinic has determined what it considers timely, then the provider’s orders to sign off list should be monitored and worked accordingly. Your clinic needs a documented policy for this process.
SuccessEHS Recommendations

For this Factor we recommend that the Orders to Sign Off list be regularly monitored and patients contacted with their results for their lab and imaging tests. The Orders to Sign Off list can be grouped by patient so that each patient’s orders can be easily viewed together. To do this click the header of the Patient column and drag it up to the grey bar above the grid.

[Image]

Documentation that the patient was notified should be done by documenting an Outbound call through Medical Messages within Clinical Console.

Adding a Message from the Order Detail Window

You can append medical messages to an order without navigating to the Medical Messages screen.

On the Order Detail screen, click Add Medical Message in the Order Detail ribbon. The Add Medical Message dialog box displays.

[Image]

The following fields will populate with the following information:

- **Date/Time** – date and time that the call is logged
- **From and By** – Name of the user logged in.
- **For** – Patient’s name.
- **Phone and Secondary** – Patient’s primary and secondary contact numbers.
- **Age** – Patient’s age.
- **Doctor** – Examining provider’s name.
- **Outgoing Call** – Selected (checked) by default (as the call is to the patient with the results of the order).
- **Reason** – Blank by default; the user will enter the appropriate reason for the call.
All fields can be edited the same as with a regular outgoing medical call. After entering the appropriate information, the user can click one of the following options:

- **Save** – Saves the call and routes it to the user in the **From** field.
- **Undo** – Cancels the call and closes the **Add Medical Call** dialog box.
- **Save & Signoff** – Saves and signs off the call. If the user does not have signoff privileges, then the call is saved to the user in the **From** field and can be followed up on from the **Medical Calls** screen. (**Save & Signoff** is only available if the user has signoff privileges for medical calls.)
  - The **Save & Signoff** button is also available on the **Phone Calls** menu ribbon, for user convenience. Both buttons function the same.

**Documentation**

*From NCQA:*

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

**Factors 1–6:** NCQA reviews:

- A documented process and
- Evidence showing how the process is met for each factor such as a report or a log or examples (to receive credit for the factor the practice must show evidence across patients not just a single example).

**Reporting**

Reporting for this Factor is accomplished by providing the relevant policy and procedure as defined in the *Policy and Procedure* section above, along with a report or log including at least one (1) week of data and an example of how the policy/procedure is met by the clinic.

A log can include screenshots of Messages for selected patient and/or recipient. Messages Reports can also be utilized in Clinical Console.

**Accessing Message Reports in Clinical Console**

1. Click **Process Reports** on the **Reports** ribbon. The **Report Selection** window displays.
2. Select **Message Reports** from the **Select Category** drop-down list.

3. Select the appropriate report from the **Select Report** drop-down list.
   
   - **All Messages for Selected Encounter** – this report allows users to view all Phone Call, Direct and Portal messages for a selected encounter number.
   
   - **All Messages for Selected Patient** – this report allows users to view all Phone Call, Direct and Portal messages sent to a selected patient.
   
   - **All Messages for Selected Recipient** – this report allows users to view all Phone Call, Direct and Portal messages sent to a specific recipient (user).
   
   - **Deleted Messages** – This report allows users to view all deleted messages.
   
   - **Messages for Selected Patient And/Or Date Range** – this report allows users to view all Phone Call, Direct and Portal messages sent to a selected patient during a specific date range, or simply for a specific date range (regardless of patient).

4. Enter the appropriate search criteria in the **Find Data That Match These Criteria** region.

5. Select **Preview** to preview the report. The report will display in a separate window. You can print the report after viewing it.
   
   — or —
   
   Click **Print** to print the report without viewing it.

**Factor 6: Following up with in-patient facilities on newborn hearing and blood-spot screening**

From NCQA:

*Factor 6: The practice follows up with the hospital or state health department if it does not receive screening results.*

Most states mandate that birthing facilities perform a newborn blood-spot screening for a number of conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns.

Adult-only practices may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.

**Policy and Procedure**

To meet this Factor, your practice should develop a written process or procedure to follow up with in-patient facilities on newborn hearing and blood-spot screening.
SuccessEHS Recommendations

WORKFLOW RECOMMENDATIONS

During the first newborn visit with the provider, place a non-billable order on the superbill for the newborn hearing and blood spot screenings. This order should be set up in CMC with a delinquency date of 30 days.

Once results are received on the order, the report can be scanned and attached to the order, which will mark the order as performed and move it to the provider’s Orders To Sign Off task list for review.

If the order has no results by the delinquency date then it will move to the Delinquent Orders Without Results list. Once the order has become delinquent, the practice should follow up with the inpatient facility to obtain results.

Documentation

From NCQA:

For all factors that require a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factors 1–6: NCQA reviews:

– A documented process and
– Evidence showing how the process is met for each factor such as a report or a log or examples (to receive credit for the factor the practice must show evidence across patients not just a single example).

Reporting

Reporting for this Factor is accomplished by providing the relevant policy and procedure as defined in the Policy and Procedure section above, along with a report or log including at least one (1) week of data and an example of how the policy/procedure is met by the clinic.

A Success Practice Analytics report has been provided to assist in reporting for this Factor. Report 5A6 – Tracking of Newborn Hearing and Blood-Spot Screening is available with this toolkit. The report includes a prompt to enter the specific CPT code(s) used to tracking newborn screenings and displays the date performed, delinquent date and order comments.

Factor 7: More than 30 percent of laboratory orders are electronically recorded in the patient record

AND

Factor 8: More than 30 percent of radiology orders are electronically recorded in the patient record

From NCQA:

Factors 7 & 8: Lab and imaging test orders are recorded in the patient medical record electronically. CMS provides the following additional information: “If the practice writes fewer than 100 laboratory or radiology orders during the reporting period,” it may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.
**SuccessEHS Recommendations (Factor 7)**

Factor 7 aligns with *Meaningful Use Stage 2 CPOE – Laboratory*

**SuccessEHS Recommendations (Factor 8)**

Factor 8 aligns with *Meaningful Use Stage 2 CPOE – Radiology.*

**Documentation**

*From NCQA:*

**Factor 7:** NCQA reviews reports from the practice’s electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- **Denominator** = Number of lab tests ordered during the reporting period.
- **Numerator** = Number of lab tests ordered that are electronically recorded in the patient record.

**Factor 8:** NCQA reviews reports from the practice’s electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent period of at least three months:

- **Denominator** = Number of radiology tests ordered during the reporting period.
- **Numerator** = Number of radiology tests ordered that are electronically recorded in the patient record.

**Reporting**

Reporting for this Factor is accomplished by using the Meaningful Use Report Card for Stage 2 CPOE – Radiology and CPOE – Laboratory:

**Factor 9:** Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record

*From NCQA:*

**Factor 9:** The practice electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical records. Looking up the information in a separate system and manual data entry into the electronic medical record does not meet the requirement.

CMS provides the following additional information: “If the practice orders no lab tests whose results are in a positive or negative affirmation or numeric format during the reporting period,” it may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.
SuccessEHS Recommendations

Factor 9 aligns with **Meaningful Use Stage 2 Measure Structured Lab Results**.

Labs should be configured with components that are set up as structured data (Quantitative or Coded text components). Any results that are a quantitative, positive, or negative value should be documented within the structured component so the data is reportable.

Order results should not be entered in the **Result Comments** field or attached to the order as an attachment, or that order will not count towards your numerator.

The following workflows will help ensure that your lab components are configured with the correct result type (Coded Text or Quantitative).

**If you are using a lab interface:**

1. Go to the **System Administration** mode in Clinical Console and select the **Interface Utilities** tab.
2. Select **Lab Compendium**. This screen will list all available vendors. Select the orders column located by the **Vendor Name** that you are interfaced with.
3. The **LIS Association** table will display. Select the **View Links** button at the bottom of the screen.
4. Highlight the order that you would like to edit to view the result components associated to the order, then select **Build Profile**.
5. Make note of any result components associated to the order.
6. Return to the **Lab Compendium** screen and choose the **Clinic Configuration** tab.
7. Open your starter set by selecting the plus sign (+) next to the words **Starter Set**.
8. Select Result Components.
9. Find the components that you wrote down in step five, and click the **Edit** button.
10. The **Edit Component** screen will display. This screen will allow you to set up your result code as coded text or quantitative.
11. Continue with step 1 under the **Setting Up Your Result Components** section below.

**If you are not using a lab interface:**

1. Go to **System Administration** mode in Clinical Console and select the plus sign (+) next to the words **Starter Set**.
2. Select **Path/Labs** and identify the orders that need to be set up as structured data.
3. Select the **Results** column for the order that you are setting up.
4. Open the **Edit Component Details** screen for the components associated to the order by double clicking the component(s) under the **Selected Components** section located on the right side of the screen.
5. Continue with Step 1 under the **Setting Up Your Result Components** section below.
SETTING UP YOUR RESULT COMPONENTS

Coded Text

1. Select Coded Text in the Result type drop down menu.
2. The data box at the bottom will become active and you can check any of the items listed as possible answers.
3. If you do not have in the list the choices you need, you can add by selecting the Edit Coded Text button in the ribbon of this window.
4. Click on the green plus to add a choice. It is important that you type in the Code – the description is optional.
5. Continue until you have added all the choices you need.
6. Click Save and Exit.
7. Select your newly added choices from the list to associate them to the result component.
8. Click Save and Exit.

Quantitative

1. Select Quantitative in the Result type drop down menu
2. Units is a required field. If there is not a unit for this component, you will need to select the empty space.
3. If you do not have in the list the choices you need, you can add choices.
4. Click Edit Unit in the menu ribbon.
5. Click the green plus to add a choice.
6. Continue until you have added all the choices you need.
7. Click Save and Exit.
8. Review anything added; additions will not automatically be checked.
9. You can enter a low and high range for normal.
10. Click Save and Exit.

To add result components to an order:

1. Go to System Administration mode in Clinical Console and select the plus sign (+) next to the words Starter Set.
2. Select Path/Labs and identify the orders that need to be set up as structured data.
3. Select the Results column for the order that you are setting up.
4. Select the components you would like to associate to the order on the left side of the screen. You can select multiple components by holding down your CTRL key.
5. Select the right arrow to move those components to the right side of the screen.
6. Click Save & Exit.

Documentation

From NCQA:

**Factor 9: NCQA reviews reports from the practice’s electronic system.**

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- **Denominator** = Number of lab tests ordered during the reporting period with results expressed in a positive or negative affirmation or as a number.

- **Numerator** = Number of lab tests whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.

Reporting

Reporting for this Factor is available via the **Structured Lab Results** measure within the **Meaningful Use Report Card** in Clinical Console.

The Meaningful Use Report calculates the following:

**Denominator:**

All Path/Lab Order types in which:

- Performed date is during the EHR reporting period
  
  **AND**
  
  - At least 1 result component configured for the order = a **Quantitative** value
  
  **OR**
  
  - One of the following **Coded Text** values:
    
    - "Positive" (any of these values should be considered Positive: positive, pos, +, ++, ++++, +++, ++++, +++++, +#, #+, >#, <$, >=#, <=#, reactive, abnormal, present)
"Negative" (any of these values should be considered Negative: negative, neg, -, nonreactive, normal, absent, not present)

- Excludes Deferred Orders, Orders marked as “Not Performed” or Deleted Orders

**Numerator:**

All Path/Lab Order types included in the denominator in which:

- Reported date or performed date is during the EHR reporting period
- Component Result Type attached to order = **Quantitative**
- Coded Text AND Observation Value = "**Positive**" (refer to list above for Positive values) or "**Negative**" (refer to the list above for Negative values), OR **Numerical** (Count all Path/Lab order types in which the above named Observation value is met - do not eliminate duplicates.)

**Factor 10: More than 10 percent of scans and tests that result in an image are accessible electronically**

From NCQA:

**Factor 10:** Imaging results that include a written report and may include images are integrated into the medical record electronically. Looking up information in a separate system and manual data entry into the electronic medical record does not meet the requirement.

A scanned PDF of the image (not of the report) in the medical record that can be retrieved and reviewed by the practice meets the requirement.

To meet this Meaningful Use requirement, the practice is expected to incorporate the image and accompanying information into Certified EHR Technology (CEHRT) or provide an indication in CEHRT that the image and accompanying information are available for a given patient in another technology and provide a link to that image and accompanying information. CMS states that the “link must conform to the certification requirements associated with objective in the ONC final rule:

CMS states:

- “Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.”
- “A link to where the image and accompanying information is stored is available in CEHRT.”
- “Images and imaging results that are scanned into the CEHRT may be counted in the numerator.”

CMS provides exclusions “any eligible provider (EP) who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the reporting period.

Practices may enter an NA response and must provide a written explanation in the Support Text/Notes box in the Survey Tool.

**SuccessEHS Recommendations**

Factor 10 aligns with Meaningful Use Stage 2 measure Imaging Results.
Documentation

From NCQA:

NCQA reviews reports from the practice’s electronic system.

The practice calculates a percentage that requires a numerator and a denominator, based on a recent three-month period:

- Denominator = Number of tests whose result is one or more images ordered during the reporting period.
- Numerator = Number of imaging results in the denominator that are accessible through the practice’s electronic system.

Reporting

Reporting for this Factor is accomplished through the Meaningful Use Report Card for Stage 2 measure Imaging Results:
**Element 5B: Referral Tracking and Follow-up**

**Note** - **Element B is a Must-Pass item.**

The practice coordinates referrals by:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Tracks referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports.</td>
</tr>
</tbody>
</table>

**Note** - **Factor 8 is a Critical Factor.**

**VALUE:** 6 points

<table>
<thead>
<tr>
<th>SCORING</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 9-10 factors (including factor 8).</td>
<td>The practice meets 7-8 factors (including factor 8).</td>
<td>The Practice meets 4-6 factors (including factor 8).</td>
<td>The practice meets 2-3 factors (including factor 8).</td>
<td>The Practice meets 0-1 factors (or does not meet factor 8).</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation**

MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

Referrals tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient’s treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect). This factor includes referrals to medical specialists, mental health and substance abuse specialists and other services.

**Factor 8: Tracks referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports**

**From NCQA:**

*Factor 8:* A tracking report includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist’s office and documents its effort to retrieve the report in a log or an electronic system.

**Note** - **Factor 8 is a Critical Factor.**
Policy and Procedure

To meet this factor, the practice must provide a written policy stating their procedure for tracking referrals, including the process for determining the required timing to receive a report. This Factor also requires a policy and procedure for each office to follow regarding what is deemed delinquent in your practice, and the procedure that is followed to obtain timely results.

SuccessEHS Recommendations

OVERVIEW

Referral Tracking can mean more than tracking a referral/consult. It can mean tracking orders sent outside of the clinic for various order types such as Radiology, Path/Labs, Procedures or Consults. Tracking these orders and following up with the patient in a timely manner is essential to proper care of the patient. In an effort to add more flexibility to tracking orders, additional tracking features have been added to the application. The additional fields/tracking features have also been added to the Success Practice Analytics universe for reporting purposes and providing tracking logs as needed.

WORKFLOW

Currently in the application, we can track orders based on whether we expect a result to be received for a particular order. This tracking field is called Results Not Required and can be found in the Order Properties window for each Starter Set in the System Administration Console (excluding Immunizations).

As long as this flag is not set in System Administration for an order, it will drive the order to Clinical Console within the Pending Results section awaiting results to be entered/scanned to the order. Pending Results will track all orders and will populate the provider’s Organizer based on the examining doctor on the encounter.
The **Order Tracking** feature allows you to track consults by inputting relevant information and setting follow-up reminders. For an order to have additional tracking, you must first have the **Results Not Required** property deselected (unchecked) – meaning that you are tracking whether results are received for that order.

By default, all consults where Results Not Required is unchecked will be added to the Order Tracking Queue. You may add or remove this property from orders by going to the specific **Order Properties** window in the System Administration mode in Clinical Console, and checking/unchecking the property.

1. First select the Compass icon in Clinical Console. Select **System Administration** from the **Mode** menu.

![System Administration Mode](image)

2. Select the appropriate Starter Set or Picklist section to modify Order Properties.

3. Once you’ve selected the correct list on the left, select **Edit** to open the Order Property page.

![Order Property Page](image)

4. The **Order Property** page will launch; you may modify the properties of the order (see screen shot below).

5. The **Order Tracking** property will be checked by default for all consults that have **Results Not Required** unchecked. This will allow the order to feed to the new Order Tracking View within the **Order Management** section of Clinical Console (i.e., the **Order Management** section encompasses...
the Pending Results and Order Tracking views).

Order Details

For all Orders marked for Order Tracking, there is an Order Tracking tab within the Order Detail.

Several properties are available within the Order Tracking tab.

- **Appointment Information** – Users have several options to track orders related to Appointment data.
  - After the appointment information has been confirmed, users are able to enter an appointment date and time into the appointment date field.
  - Users can use the calendar option or simply type in the date and time of the appointment.
If you want the system to calculate a due date for follow up, you must enter the follow up information in the **After Appt., follow up in** field. The follow-up date is intended to provide a date that the consult should be followed up on to determine if the patient was seen and/or when a report is expected. This date is not when the patient should be seen again.

Defining the follow up information will automatically calculate the **F/U On** information shown above.

First define a value (i.e. a numerical value) in the value box. Then select the appropriate unit from the list (i.e. **Days**, **Weeks**, or **Months**).

This will trigger the system to calculate the **F/U On** date (i.e. the system will take the appointment date and add the follow up information to calculate the **F/U On** date – see example below.)

The **F/U On** date has populated with 12/28/2011 and with the same time as the appointment.

Enter pertinent notes for the referral in the **Notes** field.

Filtering options allow users to view orders that are missing appt. data, follow up date is due today or overdue and within so many days before the appt. date or follow up date. These filtering options apply to the main **Order Tracking** tab and allow the users to only see orders in the state selected below rather than all orders that are outstanding (**Pending Results**).
If the original appt. could not be kept and the patient has been rescheduled, the Order Detail will allow users to document the re-schedule up to one time. Users may then document the new appointment date without affecting the original appointment date. Both dates are tracked in the system for reporting purposes.

Should the patient re-schedule again, users would simply change the reschedule appt date. If the appt. is marked as reschedule, the F/U On date is then calculated by the new appt. date rather than the original appt. date.

Order Tracking within Orders Mgmt

Only orders with the order tracking flag set will show in the Order Tracking tab shown above. All the information populated within the order detail (i.e. authorization required, authorization number, appt. date/time, etc.) will also feed to the main Order Tracking tab.

Using the filter options discussed above, users can define which orders they want to appear in their list at a given time (i.e., consults due today or that are overdue as an example).
All columns can be re-sized, grouped, or rearranged based on user preference.

The tab as well as the node in the **Navigation** pane will reflect the number of orders showing within that grid at all times.

**Following up to obtain a specialist’s report:**

Ordering and maintaining delinquency measures on orders is important in monitoring delinquent reports. Below you will find recommendations for ordering and tracking delinquent results in the software.

**WORKFLOW RECOMMENDATIONS**

You can track delinquent referrals through our **Order Tracking** functionality, which is described in detail in Factor 2 above.

You can filter the orders in this screen by using the **Filter Results** button. Filtering options allow users to view orders that are missing appointment data, orders where the follow-up date is due today or overdue, and orders within so many days before the appointment date or follow-up date. These filtering options apply to the main **Order Tracking** tab and allow the users to only see orders in the state selected below rather than all orders that are outstanding (**Pending Results**).
Attempts to obtain the specialist report or any pertinent information regarding an attempt to follow-up on the consult should be documented in the Notes field.

Once the specialist report has been received, scan and attach the report from the referring provider to the consult. Access the Order Details icon from Order Tracking, and select the Attach icon in the ribbon. Then, select Save and Exit. The order will move from Order Tracking to the ordering provider’s Orders to Sign off list.

Documentation

From NCQA:

For all factors that require a documented process, the documented process must include a date of implementation or revision and must be in place for at least three months prior to submitting the PCMH 2014 Survey Tool.

Factor 8: For each factor, NCQA reviews a documented process and a report, log, or other means of demonstrating that its process is followed. A paper log or screen shot showing electronic capabilities is acceptable. The report may be system generated or may be based on at least one week (five days) of referrals, with de-identified patient data.

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report 5B8 – Tracking Referral Follow-Up. Data for this report includes patient ID, referral date, referred to, follow up date, notes, and results.
PCMH Standard 6: Performance Measurement and Quality Improvement

From NCQA:

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

Total point value: 20 points

Element 6A: Measure Clinical Quality Performance

At least annually, the practice measures or receives data on:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>At least two immunization measures.</td>
</tr>
<tr>
<td>2</td>
<td>At least two other preventive care measures.</td>
</tr>
<tr>
<td>3</td>
<td>At least three chronic or acute care clinical measures.</td>
</tr>
<tr>
<td>4</td>
<td>Performance data stratified for vulnerable populations (to assess disparities in care).</td>
</tr>
</tbody>
</table>

VALUE: 3 points

SCORING:

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors.</td>
<td>The practice meets 3 factors.</td>
<td>The practice meets 2 factors.</td>
<td>The practice meets 1 factor.</td>
<td>The Practice meets no factors.</td>
<td></td>
</tr>
</tbody>
</table>

Explanation

The practice reviews its performance on a range of measures to help it understand its care delivery system’s strengths and opportunities for improvement. Data may be from internal or external sources. If an external source (such as a health plan) provides the data, the practice must state that the information represents 75 percent of its eligible population. Although some measures may fit into multiple categories appropriately, each measure may be used only once for this element. When it selects measures of performance, the practice documents the following for each measure: period of measurement, number of patients represented by the data, rate (percent) based on a numerator and denominator.

The practice documents the period of measurement, the number of patients represented by the data and the patient selection process. When possible, the practice uses measures from existing sources and other reporting activities it is involved in (e.g., PQRS, Meaningful Use, UDS, HEDIS). The following are examples of broadly used, widely accepted measures:

NQF-endorsed measures: You may find information on the full set of NQF-endorsed measures at http://www.qualityforum.org. The complete specifications for NQF measures are available from the organization that developed and submitted the measures to NQF.
Other standardized measures:

- Measures developed by national accreditors (e.g., NCQA, JCAHO).
- Measures developed by the AMA PCPI. Find the complete list of AMA PCPI measures at http://www.ama-assn.org/ama/pub/category/4837.html.
- Measures developed by government agencies (e.g., CMS, AHRQ) or state agencies.

When selecting measurement activities, the practice considers the criteria and systematic process used in PCMH 4, Element A, to identify patients who may benefit from care management.

**Factor 1: At least two immunization measures**

*From NCQA:*

**Factor 1:** The practice measures rates of immunization appropriate to the populations it manages.

The practice uses measures that monitor for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) or United States Preventative Services Task Force (USPSTF).

**SuccessEHS Recommendations**

The SuccessEHS software implements preventive measures in the Clinical Event Manager (CEM). CEM can be used to build rules to identify patients needing preventive care services. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.

If no one in your clinic is proficient in the building and running of CEM rules, please contact SuccessEHS support at 877-866-4347 or helpdesk@ehsmed.com to sign up for a training class.

The following example is monitoring annual flu vaccines for an adult practice:
Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1–4: NCQA reviews reports or recognition results showing performance measures.

For Renewal Surveys: The practice needs to provide reports showing that it has measured annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

Reporting

Reporting for this Factor is available via the Success Practice Analytics Report 6A1 – Immunizations.

- **Denominator:** Patient population from the CEM rule(s) selected by the user identified as needing immunization services who’ve had a relevant visit during the selected timeframe
- **Numerator:** Out of those patients which ones have had the selected immunization

**Factor 2: At least two other preventive care measures**

From NCQA:

**Factor 2:** The CMS definition of preventive services is “routine health care that includes screenings, checkups and patient counseling to prevent illnesses, diseases or other health problems.” (http://www.healthcare.gov/law/about/provisions/services/lists.html)

Preventive measures encompass a practice’s entire population and are not limited to specific measures for a patient population with chronic conditions. The intent is that the practice develops activities to improve quality of care for all patients. Preventive measures include:

- Services recommended by the U.S. Preventive Services Task Force (USPSTF).
- Preventive care and screenings for children and for women, as recommended by the Health Resources and Services Administration (HRSA).
- Other standardized preventive measures, including those identified in Bright Futures for pediatric patients.
Additional immunizations do not meet the requirement. Examples of acceptable measures include:

- Cancer screening, including age- and sex-appropriate screenings, such as colorectal screening for men and mammograms for women.
- Developmental screening for pediatric patients.
- Osteoporosis screening for appropriate populations.
- Depression screening in adults or adolescents, or in patients with chronic conditions or co-morbidities.
- ADHD screening.
- Assessment of behaviors affecting health, such as smoking status, BMI, alcohol use and substance use disorders.

**SuccessEHS Recommendations**

The SuccessEHS software implements preventive measures in the **Clinical Event Manager (CEM)**. CEM can be used to build rules to identify patients needing preventive care services. In addition it can be used to complete an event on the patient, such as sending them a letter or email requesting that they come in for the needed service or place an order in the patients chart for the needed service.

If no one in your clinic is proficient in the building and running of CEM rules, please contact Greenway Support at 877-866-4347 or helpdesk@ehsmed.com to sign up for a training class.

The following example uses colorectal screening.
Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1–4: NCQA reviews reports or recognition results showing performance measures.

For Renewal Surveys: The practice needs to provide reports showing that it has measured annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

Reporting

Reporting for this Factor is available via Success Practice Analytics. Preventive measures reports included in the toolkit are: Colorectal Cancer, Pap Test Analysis, and PSA.

- **Denominator:** Patient population from the CEM rule(s) selected by the user identified as preventive care services who’ve had a relevant visit during the selected timeframe
- **Numerator:** Out of those patients which ones were compliant for the selected screening or test

**Factor 3: At least three chronic or acute care clinical measures**

From NCQA:

*Factor 3:* Chronic or acute care clinical measures may be associated with the conditions that are tracked by the practice (e.g., diabetes, heart disease, asthma, depression, chronic back pain, otitis media), based on evidence-based guidelines. The practice may choose one measure from each of three or more different conditions. Three or more measures related to a specific condition meet the requirement.

Practices where 75 percent or more of clinicians have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP) or the Diabetes Recognition Program (DRP) receive automatic credit for factor 3 (for recognitions that are current when the practice submits its PCMH Survey Tool).
The practice includes a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice in the Organization Background section of the PCMH ISS Survey Tool.

SuccessEHS Recommendations

To complete this Factor, be sure to record the necessary data in the patient’s record to track and measure the three chronic or acute care clinical measures chosen by your practice. This is done by using the documentation and charting tools available in the SuccessEHS system such as Medcin, Order Management, and Medications.

Evidence-based guidelines for your chosen measures can be built using the Clinical Event Manager to configure rules based on the information in your patient’s records. Clinical Event Manager allows you to configure rules based on ICDs, CPTs, Lab Test Results, and Medcin findings, among others. For more information on how to configure Clinical Event Manager rules, please refer to available Clinical Event Manager classes available on the Customer Community.

Once Clinical Event Manager rules are in place, clinical users will be alerted at the point of care when a patient qualifies for one or more rules.

1. The Alerts column displays a red dot to indicate that the patient has alerts. In addition, a red exclamation point displays on the Patient Alerts icon.

2. Selecting the Patient Alerts icon lets the user view any active alerts for the patient or the user can access Patient Alerts within the patient’s chart by accessing the Patient Alerts tab.
3. Rules set up as Clinical Decision Support rules will also prompt the provider upon submitting the patient's superbill. To set up a rule as a Clinical Decision Support rule, simply check the Clinical Decision Support checkbox for the rule on the Rule Definitions screen in CEM.

4. Checking the Clinical Decision Support checkbox on a rule will indicate it as a Clinical Decision Support rule.

The above is an example of a Clinical Decision Support rule alert. Clicking Return will return the user to the patient's superbill to allow the provider to take appropriate actions.

Using Clinical Event Manager, you can associate actions to your rules that will allow you to proactively contact patients to return to the office for necessary visits and tests. Actions can be configured that will print a letter for a patient, send the patient an email, place the patient on a phone call list, or send a message to the patient's Portal account. For more information on configuring CEM rules, protocols, and actions, please refer to available Clinical Event Manager classes available through the Customer Portal.

The following screen shots provide an example of implementation of evidence-based guidelines for one important condition. We have selected Diabetes as our first important condition.

Using Clinical Event Manager, alerts and patient lists can be generated to notify clinicians when diabetic patients are due for their A1c.
Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1–4: NCQA reviews reports or recognition results showing performance measures.

For Renewal Surveys: The practice needs to provide reports showing that it has measured annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

Reporting

Reporting for this Factor is available via Success Practice Analytics. Chronic or acute care condition reports included in the toolkit are: CAD LDL Analysis, DM A1C Analysis, and Hypertension BP Analysis.

- **Denominator:** Patient population from the CEM rule(s) chosen by the user with the selected condition who’ve had a relevant visit during the selected timeframe
- **Numerator:** Out of those patients which ones were compliant for the selected measure

Factor 4: Performance data stratified for vulnerable populations (to assess disparities in care)

From NCQA:

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

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

SuccessEHS Recommendations

The SuccessEHS software captures patient demographic population information such as language best served in, insurance, age, gender, and income level results in Patient Administration. Ensuring your staff are capturing the demographic data of the patient population will assist in breaking down the reports by certain indicators to track vulnerable groups.

Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1–4: NCQA reviews reports or recognition results showing performance measures.
For Renewal Surveys: The practice needs to provide reports showing that it has measured annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

**Reporting**

The reports that we have provided for 6A1, 6A2 and 6A3 all include a detail tab that breaks down the results by race and ethnicity and by insurance (see note).

**Note** - Some reports do not include break down by insurance due to configuration limitations.

**Element 6B: Measure Resource Use and Care Coordination**

At least annually, the practice measures or receives quantitative data on:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>At least two measures related to care coordination.</td>
</tr>
<tr>
<td>2</td>
<td>At least two utilization measures affecting health care costs.</td>
</tr>
</tbody>
</table>

**VALUE:** 3 points

<table>
<thead>
<tr>
<th>SCORING:</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The practice meets all 2 factors.</td>
<td>No scoring offered.</td>
<td>The practice meets 1 factor.</td>
<td>No scoring offered.</td>
<td>The Practice meets no factors.</td>
</tr>
</tbody>
</table>

**Explanation**

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

The practice documents the period of measurement, the number of patients represented by the data and the patient selection process.

**Factor 1: At least two measures related to care coordination**

*From NCQA:*

*Factor 1:* A care coordination measure assesses “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.” (AHRQ)
The NQF provides the following examples of care coordination performance measures:

- Cardiac rehabilitation patient referral from inpatient and outpatient settings.
- Patients with a transient ischemic event ER visit who had a follow-up office visit.
- Biopsy follow-up.
- Reconciled medication list received by discharged patients (inpatient discharge to home/self-care or any other site of care).
- Transition record, with specified elements received by discharged patients (inpatient discharge to home/self-care or any other site of care).
- Timely transmission of transition record (inpatient discharge to home/self-care or any other site of care).
- Transition record, with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self-care]).
- Melanoma continuity of care-recall system.
- Three-Item Care Transitions Measure (CTM-3).

Measuring adherence to agreements (see PCMH 5 Element B) may be used to meet the factor.

Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1, 2: NCQA reviews reports showing practice performance. Reports compare “better” or “worse” results on specific metrics and may include aggregated information.

For Renewal Surveys: For Factor 2 only, the practice provides reports showing that it has measured annually for two years (current year and previous year).

Reporting

Reporting for this factor can be done through the Meaningful Use/CQM report card. By running reports at the beginning of 2 years, then again at the end of 2 years, you can show your comparison and contrasting of improvements.

Factor 2: At least two utilization measures affecting health care costs

From NCQA:

Factor 2: The practice uses resources judiciously to help patients receive appropriate care. The types of measures monitored for this factor are intended to help practices understand how efficiently they provide care, and may include ER visits, potentially avoidable hospitalizations and hospital readmissions, redundant imaging or lab tests, prescribing generic medications vs. brand name medications and number of specialist referrals. A no-show rate is not an acceptable measure to meet this requirement. Practices may use data from one or more payers that cover at least 75 percent of patients, or may collect data over time.
SuccessEHS Recommendations

SuccessEHS offers several features that assist you in using resources judiciously to provide patient care. Some examples of those features are listed below.

**Formulary** functionality allows the user to retrieve and display prescription drug formulary information using Surescripts-RxHub data sources. This functionality will display to you less expensive formulary alternatives for prescribed medications when they exist. You must be using Extended eRx to use this functionality. If you are not currently using Extended eRx, but are interested in having this turned on for your practice, please contact the SuccessEHS help desk so they can begin that process.

**Clinical Event Manager** can be used to help your patients avoid hospitalizations and readmissions by enabling you to identify those patients in need of important services, and then reaching out to those patients to have them come in and receive those services. The CEM proactively alerts providers if patients do not comply with the guidelines and protocols.

SuccessEHS uses the **Clinical Event Manager** to create lists of patients that match certain events such as mammograms, pediatric screenings, etc., which can be used to generate telephone calls, letters, and e-mails as appropriate.

To create new rules in the Clinical Event Manager, follow the steps provided in the training documentation found in the Customer Community.

**Documentation**

**From NCQA:**

- If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.
- **Factors 1, 2:** NCQA reviews reports showing practice performance. Reports compare “better” or “worse” results on specific metrics and may include aggregated information.
- For Renewal Surveys: For Factor 2 only, the practice provides reports showing that it has measured annually for two years (current year and previous year).

**Reporting**

Reporting for this factor can be done through the Meaningful Use/CQM report card or SuccessEHS Practice Analytics.

Within the MU/CQM dashboard, users can run reports at the beginning of 2 years, then again at the end of 2 years, to show your comparison and contrast of improvements.

Reports via Success Practice Analytics are also available and can be refreshed using different timeframes to compare and contrast improvements. Examples available: Generic vs Brand Medications, Radiology Test Utilization, and Specialist Referrals Utilization.
Element 6C: Measure Patient/Family Experience

At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1      | The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:  
- Access  
- Communication  
- Coordination  
- Whole-person care/self-management support |
| 2      | The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician Group survey tool. |
| 3      | The practice obtains feedback on the experiences of vulnerable patient groups. |
| 4      | The practice obtains feedback from patients/families through qualitative means. |
| VALUE: | 4 points |
| SCORING: | 100% | 75% | 50% | 25% | 0% |
| The practice meets all 4 factors. | The practice meets 3 factors. | The Practice meets 2 factors. | The practice meets 1 factor. | The Practice does not provide services. |

Explanation

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

Factor 1: The practice conducts a survey to evaluate patient/family experiences on at least three of the following categories: Access, Communication, Coordination, and Whole-person care/self-management support

From NCQA:

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

- Access (may include routine, urgent and after-hours care).
Communication with the practice, clinicians and staff (may include “feeling respected and listened to” and “able to get answers to questions”).

Coordination of care may include being informed and up-to-date on referrals to specialists, changes in medications and lab or imaging results.

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

SuccessEHS Recommendations

For this Factor the practice should create a survey and then conduct that survey with their patients.

Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1–4: NCQA reviews reports with summarized results of patient feedback.

A practice that is pursuing NCQA Distinction must provide a report.

For Renewal Surveys: The practice needs to provide reports showing that it has measured at least annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

Reporting

Reporting for this Factor will be accomplished by summarizing results of patient feedback and providing those to NCQA.

Factor 2: The practice uses the CAHPS Patient-Centered Medical Home (PCMH) survey tool

From NCQA:

Factor 2: The practice uses the standardized CAHPS PCMH Survey Tool to collect patient experience data. A vendor IS NOT required to administer the survey if the practice wants to meet the requirements for factor 2. The practice must administer the entire PCMH CAHPS survey, not just sections of the survey, to receive credit.

A certified vendor is ONLY required if the practice wants to receive NCQA Distinction in addition to being recognized, see note.

Note: Practices can earn Distinction from NCQA for using the CAHPS PCMH survey to collect patient experience data and for:

– Using a specific methodology to collect the data.
– Using a certified vendor to collect the data.
– Reporting results to NCQA, to be used to benchmark patient-experience data.

**SuccessEHS Recommendations**

This factor requires use of CAHPS PCMH Survey tool. Reference the NCQA website for more information on accessing this survey.


**Documentation**

**From NCQA:**

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

**Factors 1–4:** NCQA reviews reports with summarized results of patient feedback.

A practice that is pursuing NCQA Distinction must provide a report.

For Renewal Surveys: The practice needs to provide reports showing that it has measured at least annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

**Reporting**

Reporting for this Factor will be accomplished by summarizing results of patient feedback and providing those to NCQA.

**Factor 3: The practice obtains feedback on the experiences of vulnerable patient groups**

**From NCQA:**

**Factor 3:** Vulnerable populations are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability,” (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.

The practice uses a survey or another method to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may provide the basis for the subgroups.

**SuccessEHS Recommendations**

Patients that are considered a part of the Vulnerable Population should be identified so that when they complete a survey, those results may be identified separately. There are several options of identifying patients in the software, including:

**OPTION 1: PATIENT STATUS**

Tracking vulnerable patients is done via the Patient Status **Vulnerable Patient**, which is indicated on the **Demographics** tab in **Patient Administration**.
Creating a Patient Status

1. Access the Account and Patient Statuses window in the System Administration Console.

2. Click New Status to add a new account/patient status. An Account/Patient Status dialog box displays.

3. Enter an appropriate Status Description.

4. If you want to associate a Standard Note to the Account or Patient Status, click in the Associated Standard Note field and search for the Standard Note.

   **Note** - If a standard note is entered here, then it is automatically added to the Notes tab for that patient or all patients associated to the account when the status is applied to a patient or account.

5. Under Type, select Account, Patient, or both to indicate how the status will be used.

6. **Account Status Options** are enabled only when you select type Account Status. Select (check) Do Not Send Statement, Do Not Age, Prevent Collection Module Activity, Fee Scheduling Uses This Status, or any combination of these three options.

7. If Patient Status has been selected as a Type, select (check) Exclude from Collaborative Reporting (if desired) to omit patients with this status from appearing on collaborative reports.

8. Select Active in the Status drop-down menu.

9. Click Apply or Save to save your changes and keep the window open.

10. Click New Status to clear the window and enter another code.

11. Click Save & Exit to save your changes and close the window.
Assigning a Patient Status

1. Access a patient account on the **Patient Administration** dialog box.
   —or—
   Add a new patient.

2. Click in the **Patient Status** box. The **Patient Statuses** dialog box displays.

3. Click **Add**. The **Find Patient or Account Status** dialog box displays.

4. Select a patient status. The status displays on the **Patient Statuses** dialog box.

5. Click **OK**.

6. The **Vulnerable Patient** status will be used as a report value in reporting for Factor 3.

**OPTION 2: USER DEFINED FIELD**

1. Access the User Defined Fields window in the System Administration Console.

2. Click **New User Defined Field** to add a new user-defined field. A User Defined Field Configuration dialog box displays.

3. Enter the desired name for the User Defined Field in the Field Name field.
4. Indicate the valid values for the User Defined Field. Selections include:
   - **Alphanumeric** – Alpha and numeric values as well as special characters are accepted.
   - **Numeric** – Only number values are accepted.
   - **Date** – Only calendar dates (mm/dd/yyyy format) are accepted

5. If there is a pre-defined set of values that must be selected from when using the User Defined Field in **Patient Administration**, enter the value name/description in the **Valid Values** box (80-character limit) and click **Add to List**.

6. Select **Required** if this User Defined Field must be completed before a patient record is saved in **Patient Administration**.

7. Continue entering values for the User Defined Field until all are defined.

8. Select **Active** in the **Status** drop-down menu.

9. Click **Apply** or **Save** to save your changes and keep the window open.

10. Click **New User Defined Field** to clear the window and enter another field configuration.

11. Click **Save & Exit** to save your changes and close the window.

**Documentation**

**From NCQA:**

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

**Factors 1–4:** NCQA reviews reports with summarized results of patient feedback.

A practice that is pursuing NCQA Distinction must provide a report.

For Renewal Surveys: The practice needs to provide reports showing that it has measured at least annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

**Reporting**

Reporting for this Factor will be accomplished by summarizing results of patient feedback and providing those to NCQA.

**Factor 4: The practice obtains feedback from patients/families through qualitative means**

**From NCQA:**

*Factor 4:* Qualitative feedback methods may include focus groups, individual interviews, patient walkthrough and suggestion boxes. Practices may use a feedback methodology conducive to its population of patients/families or parents, such as “virtual” participation (e.g., by phone or videoconference). Comments from surveys used to satisfy factors 1 and 2 do not meet this requirement.
Documentation

From NCQA:

If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.

Factors 1–4: NCQA reviews reports with summarized results of patient feedback.

A practice that is pursuing NCQA Distinction must provide a report.

For Renewal Surveys: The practice needs to provide reports showing that it has measured at least annually for two years (current year and previous year). If a renewing practice is currently recognized as a Level 2 or 3, this element is available for attestation. However, if a practice is unable to show evidence that it has reported data annually for at least two years, it must submit as an initial applicant and may not use the streamlined renewal process.

Reporting

Reporting for this Factor is accomplished by reports with summarized results of patient feedback.

Element 6D: Implement Continuous Quality Improvement

Note - Element 6D is a Must Pass element.

The practice uses an ongoing quality improvement process to:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Set goals and analyze at least three clinical quality measures from Element 6A.</td>
</tr>
<tr>
<td>2</td>
<td>Act to improve at least three clinical quality measures from Element 6A.</td>
</tr>
<tr>
<td>3</td>
<td>Set goals and analyze at least one measure from Element 6B.</td>
</tr>
<tr>
<td>4</td>
<td>Act to improve at least one measure from Element 6B.</td>
</tr>
<tr>
<td>5</td>
<td>Set goals and analyze at least one patient experience measure from Element 6C.</td>
</tr>
<tr>
<td>6</td>
<td>Act to improve at least one patient experience measure from Element 6C.</td>
</tr>
<tr>
<td>7</td>
<td>Set goals and address at least one identified disparity in care/service for identified vulnerable populations.</td>
</tr>
</tbody>
</table>

VALUE: 4 points

<table>
<thead>
<tr>
<th>SCORING:</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The practice meets all 7 factors.</td>
<td>The practice meets 6 factors.</td>
<td>The practice meets 5 factors.</td>
<td>The practice meets 1-4 factors.</td>
<td>The practice meets 0 factors.</td>
</tr>
</tbody>
</table>
Explanation

MUST-PASS elements are considered the basic building blocks of a patient-centered medical home. Practices must earn a score of 50% or higher. All six must-pass elements are required for recognition.

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

The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action. The Institute for Healthcare Improvement (IHI) is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/).

Factor 1: Set goals and analyze at least three clinical quality measures from Element A
AND
Factor 2: Act to improve at least three clinical quality measures from Element A

From NCQA:

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

SuccessEHS Recommendations

For this Factor, it is recommended that the practice completes the PCMH Quality Measurement and Improvement Worksheet, which can be found on the NCQA Survey Tool for this specific element.

The completion of surveys from your population and the aggregation of report data for your patient population are used to complete the PMCH Quality Measurement and Improvement Worksheet.

Each practice is responsible for obtaining and collecting data on the appropriate surveys.

Documentation

From NCQA:

*Factors 1–7*: NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.

Reporting

The reporting requirements for this factor are achieved by completing the PCMH Quality Measurement and Improvement Worksheet or providing a report.
Factor 3: Set goals and analyze at least one measure from Element 6B

From NCQA:

**Factor 3:** The practice sets goals and acts to improve performance, based on clinical quality measures (measures identified in Element A), resource and care coordination measures (measures identified in Element B) and patient experience measures (measures identified in Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

SuccessEHS Recommendations

For this Factor, it is recommended that the practice completes the PCMH Quality Measurement and Improvement Worksheet, which can be found on the NCQA Survey Tool for this specific element.

The completion of surveys from your population and the aggregation of report data for your patient population are used to complete the PMCH Quality Measurement and Improvement Worksheet.

Each practice is responsible for obtaining and collecting data on the appropriate surveys.

Documentation

From NCQA:

**Factors 1–7:** NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.

Reporting

The reporting requirements for this factor are achieved by completing the PCMH Quality Measurement and Improvement Worksheet or providing a report.

Factor 4: Act to improve at least one measure from Element 6B

From NCQA:

**Factor 4:** The practice sets goals and acts to improve performance, based on clinical quality measures (measures identified in Element A), resource and care coordination measures (measures identified in Element B) and patient experience measures (measures identified in Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

SuccessEHS Recommendations

For this Factor, it is recommended that the practice completes the PCMH Quality Measurement and Improvement Worksheet, which can be found on the NCQA Survey Tool for this specific element.

The completion of surveys from your population and the aggregation of report data for your patient population are used to complete the PMCH Quality Measurement and Improvement Worksheet.

Each practice is responsible for obtaining and collecting data on the appropriate surveys.

Documentation

From NCQA:

**Factors 1–7:** NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.
Reporting
The reporting requirements for this factor are achieved by completing the PCMH Quality Measurement and Improvement Worksheet or providing a report.

Factor 5: Set goals and analyze at least one patient experience measure from Element 6C

From NCQA:

**Factor 5:** The practice sets goals and acts to improve performance, based on clinical quality measures (measures identified in Element A), resource and care coordination measures (measures identified in Element B) and patient experience measures (measures identified in Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

SuccessEHS Recommendations
For this Factor, it is recommended that the practice complete the PCMH Quality Measurement and Improvement Worksheet, which can be found on the NCQA Survey Tool for this specific element.

The completion of surveys from your population and the aggregation of report data for your patient population are used to complete the PMCH Quality Measurement and Improvement Worksheet.

Each practice is responsible for obtaining and collecting data on the appropriate surveys.

Documentation
From NCQA:

**Factors 1–7:** NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.

Reporting
The reporting requirements for this factor are achieved by completing the PCMH Quality Measurement and Improvement Worksheet or providing a report.

Factor 6: Act to improve at least one patient experience measure from Element 6C

From NCQA:

**Factor 6:** The practice sets goals and acts to improve performance, based on clinical quality measures (measures identified in Element A), resource and care coordination measures (measures identified in Element B) and patient experience measures (measures identified in Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.

SuccessEHS Recommendations
For this Factor, it is recommended that the practice completes the PCMH Quality Measurement and Improvement Worksheet, which can be found on the NCQA Survey Tool for this specific element.

The completion of surveys from your population and the aggregation of report data for your patient population are used to complete the PMCH Quality Measurement and Improvement Worksheet.
Each practice is responsible for obtaining and collecting data on the appropriate surveys.

Documentation

From NCQA:

Factors 1–7: NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.

Reporting

The reporting requirements for this factor are achieved by completing the PCMH Quality Measurement and Improvement Worksheet or providing a report.

Factor 7: Set goals and address at least one identified disparity in care/service for identified vulnerable populations

From NCQA:

Factor 7: Vulnerable populations are “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability,” (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.

The practice identifies areas of disparity among vulnerable populations, sets goals and acts to improve performance in these areas. Vulnerable groups reflect the practice’s population demographics (e.g., age, gender, race, ethnicity, language needs, education, income, type of insurance [i.e., Medicare, Medicaid, commercial], disability or health status).

Note: The care of service used does not need to be the same as identified in Element 6A.

SuccessEHS Recommendations

For this Factor, it is recommended that the practice completes the PCMH Quality Measurement and Improvement Worksheet, which can be found on the NCQA Survey Tool for this specific element.

The completion of surveys from your population and the aggregation of report data for your patient population are used to complete the PMCH Quality Measurement and Improvement Worksheet.

Each practice is responsible for obtaining and collecting data on the appropriate surveys.

Documentation

From NCQA:

Factors 1–7: NCQA reviews a report showing how the practice meets each factor, or reviews the PCMH Quality Measurement and Improvement Worksheet.

Reporting

The reporting requirements for this factor are achieved by completing the PCMH Quality Measurement and Improvement Worksheet or providing a report.
Element 6E: Demonstrate Continuous Quality Improvement

The practice demonstrates continuous quality improvement by:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Measuring the effectiveness of the actions it takes to improve the measures selected in Element 6D.</td>
</tr>
<tr>
<td>2</td>
<td>Achieving improved performance on at least two clinical quality measures.</td>
</tr>
<tr>
<td>3</td>
<td>Achieving improved performance on one utilization or care coordination measure.</td>
</tr>
<tr>
<td>4</td>
<td>Achieving improved performance on at least one patient experience measure.</td>
</tr>
</tbody>
</table>

**VALUE:** 3 points

**SCORING:**

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets 4 factors.</td>
<td>The practice meets 3 factors.</td>
<td>The Practice meets 2 factors.</td>
<td>The practice meets 1 factor.</td>
<td>The Practice meets 0 factors.</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation**

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

**Factor 1: Measuring the effectiveness of the actions it takes to improve the measures selected in Element 6D**

From NCQA:

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

In factor 1, the practice identifies the steps it has taken in Element D and evaluates these steps to improve performance. The practice is not required to demonstrate improvement in this factor.

You may either create reports to show this measure or utilize the PCMH Quality Measurement and Improvement Worksheet.

**Documentation**

From NCQA:

**Factor 1:** NCQA reviews reports or a completed PCMH Quality Measurement and Improvement Worksheet that shows how the practice meets the requirements.
Reporting

To report on this Factor you may provide either reports, recognition results, or a completed PCMH Quality Measurement and Improvement Worksheet showing performance measures over time.

**Factor 2: Achieving improved performance on at least two clinical quality measures**

*From NCQA:*

*Factor 2:* The practice demonstrates that its performance on the measures has improved over time, based on its assessment.

Credit for this Factor is also reported on the PMCH Quality Measurement and Improvement Worksheet.

**Documentation**

*From NCQA:*

*Factor 2:* NCQA reviews reports or a completed PCMH Quality Measurement and Improvement Worksheet that shows how the practice meets the requirements.

Reporting

To report on this Factor you may provide either reports via the SuccessEHS Report Card (if using one of the MU CQMs) or a completed PCMH Quality Measurement and Improvement Worksheet.

**Factor 3: Achieving improved performance on one utilization or care coordination measure**

**AND**

**Factor 4: Achieving improved performance on at least one patient experience measure**

*From NCQA:*

*Factors 3 & 4:* The practice demonstrates that its performance on the measures has improved over time, based on its assessment.

Factors 3 & 4 are met by demonstrating improvement of the performance measures that were tracked and assessed and what the results are for those improvement measures.

Documentation is completed by using the PCMH Quality Measurement and Improvement worksheet accessible from the NCQA PCMH Survey Tool.

**Documentation**

*From NCQA:*

*Factors 3 & 4:* NCQA reviews reports or a completed PCMH Quality Measurement and Improvement Worksheet that shows how the practice meets the requirements.
Reporting

Documentation is completed by providing a completed PCMH Quality Measurement and Improvement worksheet, reports demonstrating improvement, or recognition results.

Element 6F: Report Performance

The practice produces performance data reports using measures from Elements A, B, and C and shares:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Individual clinician performance results with the practice.</td>
</tr>
<tr>
<td>2</td>
<td>Practice-level performance results with the practice.</td>
</tr>
<tr>
<td>3</td>
<td>Individual clinician or practice-level performance results publicly.</td>
</tr>
<tr>
<td>4</td>
<td>Individual clinician or practice-level performance results with patients.</td>
</tr>
</tbody>
</table>

**VALUE:** 3 points

**SCORING:**

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor</td>
<td>The practice meets 3-4 factors.</td>
<td>The practice meets 2 factors.</td>
<td>The practice meets 1 factor.</td>
<td>No scoring option.</td>
<td>The Practice meets 0 factors.</td>
</tr>
</tbody>
</table>

**Explanation**

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

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

For each factor, the practice must report performance data using at least one measure from each of Elements 6A, 6B and 6C. Practices are not required to report all measures from each to meet requirements.

Practices where 75 percent or more of the eligible clinicians have earned recognition in the NCQA Heart/Stroke Recognition Program (HSRP), Diabetes Recognition Program (DRP) automatically receive credit for Element 6A performance data for recognitions that are current when the practice submits its PCMH Survey Tool. The practice should include a statement about the recognized clinicians, the name of the recognition program and the number or percentage of recognized clinicians in the practice in the Organization Background section of the PCMH ISS Survey Tool.
Factor 1: Individual clinician performance results with the practice

From NCQA:

Factor 1: The practice provides individual clinician reports to clinicians and practice staff. Reports reflect the care provided by the care team. Measure results not available at the individual clinician level do not need to be included.

Documentation

From NCQA:

Factor 1: NCQA reviews reports provided to clinicians and practice staff showing individual clinician performance and explaining how results are disseminated.

Reporting

Your practice must provide clinician reports to individual clinicians and practice staff summarizing the results from the surveys and the process for how the clinic will use them for process improvement for the individual care team.

Factor 2: Practice-level performance results with the practice

From NCQA:

Factor 2: The practice provides practice-level performance results to all clinicians and practice staff.

Documentation

From NCQA:

Factor 2: NCQA reviews reports showing practice-level performance results and explaining how results are disseminated.

Reporting

Your practice must provide a report to the entire practice summarizing the results from your surveys and your process for improvement and explain how it provides results.

Factor 3: Individual clinician or practice-level performance results publicly

From NCQA:

Factor 3: The practice reports site-specific data on its Web site, or data are made public by a health plan or other entity.

Documentation

From NCQA:

Factor 3: NCQA reviews an example of a performance report provided to the public.
Reporting
To report on this Factor you must provide an example of how you have made your results public.

**Factor 4: Individual clinician or practice-level performance results with patients**

*From NCQA:*

**Factor 4:** The practice reports site-specific performance results to patients, or makes results available to patients. The practice may use patient communications (e.g., letter, e-mail, mass mailing) to notify patients that the information is available publicly.

**Documentation**

*From NCQA:*

**Factor 4:** NCQA reviews an example of a performance report provided to patients.

**Reporting**

To report on this Factor you must provide an example of how you distributed the results to your patient population.

**Element 6G: Use Certified EHR Technology**

The practice uses a certified EHR system:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.</td>
</tr>
<tr>
<td>2</td>
<td>The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.</td>
</tr>
<tr>
<td>3</td>
<td>The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.</td>
</tr>
<tr>
<td>4</td>
<td>The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.</td>
</tr>
<tr>
<td>5</td>
<td>The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.</td>
</tr>
<tr>
<td>6</td>
<td>The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use.</td>
</tr>
<tr>
<td>7</td>
<td>The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.</td>
</tr>
<tr>
<td>8</td>
<td>The practice has access to a health information exchange.</td>
</tr>
<tr>
<td>9</td>
<td>The practice has bidirectional exchange with a health information exchange.</td>
</tr>
</tbody>
</table>
The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care. +

<table>
<thead>
<tr>
<th>VALUE:</th>
<th>Not Scored</th>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCORING:</td>
<td>No scoring option.</td>
<td>No scoring option.</td>
<td>No scoring option.</td>
<td>No scoring option.</td>
<td>No scoring option.</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation**

Factors 1, 8, and 9 require comments in the Support Text/Notes box of the Survey Tool.

Factors 4, 5, and 7 require comments in the Support Text/Notes box of the Survey Tool if NA is selected.

This element is for data collection purposes only and will not be scored.

**Note:** The CMS EHR certification ID may be found at [http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id](http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id).

The practice protects the privacy and security of the electronic health information within its certified EHR system (or modules). To meet the federal Core and Menu Meaningful Use requirements, practices must meet the designated factors (+ Core, ++ Menu) using a certified EHR that has undergone a security risk analysis, had necessary security updates and had identified security deficiencies corrected.

CMS states that objectives are as follows:

- “To protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.”
- “All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology.”

The following links provide additional information:

- Stage 1 Core Meaningful Use requirement #15, Protect Electronic Health Information: [http://www.cms.gov/EHRIncentivePrograms/Downloads/15ProtectElectronicHealthInformation.pdf](http://www.cms.gov/EHRIncentivePrograms/Downloads/15ProtectElectronicHealthInformation.pdf).
Factor 1: The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID

From NCQA:

Factor 1: The practice attests to using a certified EHR system. Since the practice may use more than one software system, all must be listed. CMS provides information on obtaining a Certification ID on their Web site at http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl#cms_ehr_certification_id. A list of Certified Health IT Products can be found at http://oncchpl.force.com/ehrcert?q=chpl.

SuccessEHS Recommendations

To obtain documentation for this factor, go to http://oncchpl.force.com/ehrcert?q=chpl. Here, you may search for the SuccessEHS product and obtain a corresponding certification ID.

Documentation

From NCQA:

Factor 1: By entering a “yes” response in the PCMH Survey Tool, the practice attests to using a Certified Electronic Health Record and that it has been issued a CMS certification ID to perform the designated CMS Meaningful Use Core and Menu requirements.

Reporting

Reporting for this Factor is completed by providing responding “Yes” in the PCMH Survey Tool that the practice attests to using a CEHRT and obtains the corresponding CMS certification ID for the SuccessEHS version the practice is on.

Factor 2: The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies

From NCQA:

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

SuccessEHS Recommendations

To meet this Factor, clinics must access the Security module of Clinical Console. At this point, the user would call the Support HelpDesk so the support representative may enter the needed password for the Configure Security Auditing section. Once the password is entered, the user may take a screen shot showing that all security auditing features have been enabled.
Documentation

From NCQA:

**Factor 2:** By entering a “yes” response in the PCMH Survey Tool, the practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies. [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/14_Protect_Electronic_Health_Information.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/14_Protect_Electronic_Health_Information.pdf)

Reporting

Reporting for this Factor is accomplished by providing a screenshot of the systems enabled security features described in the SuccessEHS Recommendations.

**Factor 3: The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically**

From NCQA:

**Factor 3:** The practice attests that it has fulfilled the CMS Meaningful Use Stage 2 Menu Measure 4 and it performs “successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.”

SuccessEHS Recommendations

The following is an excerpt from the SuccessEHS Meaningful Use Toolkit Physicians Toolkit (a) and reviews the submission of syndromic surveillance data.

**Electronic Syndromic Surveillance:** This measure requires that you test submitting Electronic Syndromic Surveillance data to a public or state health agency.

Submitting data to a public or state health agency requires that you have an interface with that agency. If you would like to establish an interface with such agency, you must contact the SuccessEHS support department to begin that process. There is a fee associated with the implementation of an interface.

This factor will be considered not applicable if none of the public health agencies to which the practice submits information has the capacity to receive the information electronically or if the practice did not collect any reportable syndromic information on their patients during the past 12 months.

Documentation

From NCQA:

**Factor 3:** By entering a “yes” response in the PCMH Survey Tool, the practice attests to its “capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.” [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/10SyndromicSurveillanceDataSubmission.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/10SyndromicSurveillanceDataSubmission.pdf)

Reporting

Reporting for this accomplished by providing reports demonstrating electronic data submittal to immunization registries, other agencies, or a screen shot demonstrating that the capability was tested.
Factor 4: The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically

From NCQA:

Factor 4: The practice attests that it has fulfilled the CMS Meaningful Use Stage 2 Measure, indicating it has “successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.

Factor is NA for any practice that:

“(1) Does not diagnose or directly treat cancer;
(2) Operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period;
(3) Operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or
(4) Operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period.”

Factor 4 aligns with Meaningful Use Stage 2 Measure: Report Cancer Cases. SuccessEHS does not support this MU2 measure.

Documentation

From NCQA:

Factor 4: By entering a “yes” response in the PCMH Survey Tool, the practice attests to its “capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. [link]

Factor 5: The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically

From NCQA:

Factor 5: The practice attests that it has fulfilled the CMS Meaningful Use Stage 2 Measure 6, indicating it has “successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.”

Factor 5 is NA for any practice that:

“(1) Does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which [any of the clinicians coming forward for recognition] are eligible, or the public health agencies in their jurisdiction;
(2) Operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which [any of the clinicians coming forward for recognition] are eligible is
capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period;

(3) Operates in a jurisdiction where no public health agency or nation specialty society for which [any of the clinicians coming forward for recognition] is eligible provides information timely on capability to receive information into their specialized registries; or

(4) Operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which [any of the clinicians coming forward for recognition] is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional [clinicians coming forward for recognition].”

Factor 5 aligns with **Meaningful Use Stage 2 Measure: Specific Case Reporting**. SuccessEHS does not support this MU measure.

**Documentation**

From NCQA:

**Factor 5:** By entering a “yes” response in the PCMH Survey Tool, the practice attests to its “capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.”


**Factor 6:** The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use

From NCQA:

**Factor 6:** The practice reports clinical quality measures to Medicare or a state (Medicaid program), as required for Meaningful Use by CMS Meaningful Use Stage 2 guidelines.

**SuccessEHS Recommendations**

The Meaningful Use Toolkit should be referenced for the most up-to-date list of Clinical Quality Measures that SuccessEHS is presently certified on.

**To generate and export your CQM files:**

1. Select the **Meaningful Use Reports** icon from the **Reports** ribbon in Clinical Console.
2. From the **Meaningful Use** tab, select **Generate**.
3. The reporting files will be generated. An email will be sent to the user when the reports are completed. The email address is taken from the **User Definitions** screen in **Security**. If no email address has been configured, you will be prompted to enter one.
4. Once the files are generated, you will receive an email. At that time, you can log back into SuccessEHS and select **Save Files** button from **Meaningful Use Reporting** dashboard to save the files.

**Documentation**

**From NCQA:**

**Factor 6:** By entering a “yes” response in the PCMH Survey Tool, the practice attests that it reports clinical quality measures to Medicare or Medicaid, as required for Meaningful Use.

**Reporting**

Reporting for this Factor is completed by providing reports demonstrating transmission to CMS or states.

**Factor 7:** The practice demonstrates the capability to submit data to immunization registries or immunization systems electronically

**From NCQA:**

**Factor 7:** The practice attests that it has fulfilled the CMS Meaningful Use Stage 1 Menu Set Measure 9, indicating it has “performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful.”

Factor 7 is NA for practices that “[administer] no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.”

**SuccessEHS Recommendations**

Reporting for this factor is done through the SuccessEHS CQM Report Card as seen in Factor 6 above. You must show proof that CQM data was transmitted to CMS or states.

**Documentation**

**From NCQA:**

**Factor 7:** By entering a “yes” response in the PCMH Survey Tool, the practice attests that it reports clinical quality measures to Medicare or Medicaid, as required for Meaningful Use.
Reporting
Reporting for this Factor is completed by providing reports demonstrating transmission to CMS or states.

**Factor 8: The practice has access to a health information exchange**

*From NCQA:*

*Factor 8:* The practice attests that it has access to and can view information in a health information exchange (HIE).

**SuccessEHS Recommendations**

An HIE will need to be configured in order to meet this Factor. Some states have HIE’s and others do not. Contact the SuccessEHS Interoperability Support team to determine if your state is accepting data before moving forward with this configuration.

**Documentation**

*From NCQA:*

*Factor 8:* By entering a “yes” response in the PCMH Survey Tool, the practice attests to its capability to view HIE information. The practice provides the name(s) of the HIE.

**Reporting**

The practice must attest to its capability to view HIE information. No other reports are required except providing information as stated in the Documentation section above.

**Factor 9: The practice has bidirectional exchange with a health information exchange**

*From NCQA:*

*Factor 9:* The practice attests that it has bidirectional communication (i.e., can send and receive information) with an HIE.

**Documentation**

*From NCQA:*

*Factor 9:* By entering a “yes” response in the PCMH Survey Tool, the practice attests to its capability to both send and receive information from an HIE. The practice provides the name(s) of the HIE.

**Reporting**

The practice must attest to its capability to send and receive (bidirectional) HIE information. No other reports are required except providing information as stated in the Documentation section above.
Factor 10: The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care

From NCQA:

Factor 10: The practice attests that it has fulfilled the CMS Meaningful Use Stage 2 Core Set Measure 12, indicating it can “[use] clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference... for [more] than 10 percent of all unique patients.”

SuccessEHS Recommendations

The Meaningful Use Toolkit should be referenced when working on this factor.

Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference when available. Reminders should be sent to unique patients with 2 office visits within 24 months prior to the reporting period. Reminders can be sent from the Clinical Event Manager module.

- Reminders sent to patient via the Clinical Event Manager (CEM) module.
  - Have your system administrator build appropriate rules, actions, and protocols in the CEM module.
  - Run applicable rules to generate lists of patients and send reminders.
  - Mark the action Complete and save.

Documentation

From NCQA:

Factor 10: By entering a “yes” response in the PCMH Survey Tool, the practice attests to “using clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference...for [more] than 10 percent of all unique patients.”
### Reporting

Reporting for this Factor is completed by providing screenshots from the **Meaningful Use Report Card measure:** Patient Reminders.

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<th>Measure</th>
<th>Type</th>
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<th>Target %</th>
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