

Submitted Questions to NCQA

2014 STANDARDS

Pre-validation credits and 2014 streamlined renewal.

I have a clinic that is currently recognized as NCQA 2011 level 2. Their recognition will be expiring next June. I wanted to know if they could use the both the HIT pre-validation and the 2014 streamlined renewal process to obtain the 2014 recognition? Thank you, Kim

Answer

Hi Kim, Yes they can use the streamline renewal process and HIT pre-validation credit. Please be reminded to upload the vendor Prevalidation Summary Approval Table, the NCQA Letter of Product Autocredit Approval and Product Implementation Letter from the vendor into the "Organizational Background" section of the ISS Survey Tool. - See more at: <http://www.ncqa.org/programs/recognition/prevalidation-program/for-practices#sthash.RzYfCqCD.dpuf> Thanks

Status: Closed

Created: 09/30/2016

Modified: 10/03/2016

Case: 00117616

Subject Areas

Programs

Application/Survey (Recognition)

PCMH - Patient-Centered Medical Home

PCMH 2014 Pre-Validation Approval

Can you tell me how long a clinic needs to wait after they have implemented a new EHR (Athena) to receive approval for the HIT Pre-Validation? I have a clinic that just purchased Athena EHR and they are in the process of preparing to apply for 2014 NCQA. Their vendor told them that they can receive auto credit for the NCQA Factors. However, they were also under the impression that they would have to wait 3 months after implementing the EHR to submit the request for the Pre-Validation Summary Approval Table. Could you please advise? Thank you, Kim

Answer

Hi Kim, The practice has to have it's EHR system implemented and in place for atleast 3 months prior to submitting it's survey tool. That also include policies and procedures as well. Thanks

Status: Closed

Created: 08/18/2016

Modified: 08/19/2016

Case: 00112764

Subject Areas

PCS

HIP - Health Information Products Standards

Health Information Line

Publication Year:2014

To ask a question about this case [click here](#).

Corporate Survey 2014- If Documentation Doesn't Pass

If an organization received feedback on their corporate survey that their documentation did not meet the requirements, can they revise documentation and submit it in their site-specific surveys?

NCQA's response:

Thanks for submitting your inquiry. That can be an option if more than 12 elements were answered in the Corporate tool. However, please follow up directly with the assigned NCQA program manager. Please let us know if you have any more questions

Name of practice documentation information

I work with a Tribal practice who house's all of their services in one building. They have the medical clinic and the tribal health and human services (THHS) side. Both of these entities work together on PCMH. However, the application and ISS tool will be used for the physicians practicing in the medical clinic. Some of their processes will have both names; the medical clinic and the THHS. Will both names need to be on the processes/agreements in order to be counted towards their documentation? For example: 5B. #2 Agreement between specialty providers. The medical clinic coordinates all of their referrals through their referred care team which is Tribal Health and Human Services. The tasks that the medical clinic does are outlined in the agreement, but the agreement is labeled with THHS name. Does the medical clinic need to have their name on this agreement as well? Or can they explain this in the ISS tool for their NCQA reviewer? Thank you for your time!

NCQA's response:

Per our phone conversation, as you indicated both sides follow the same processes and use the same EMR system. Therefore, it is fine if your policies have both names listed. However, the overall supporting data and examples must support the Tribal Medical clinic and not Tribal Health and Human services. You may also provide an explanation in the text box in elements where you think clarification re: the documentation would be helpful.

Printed materials in other languages

I am working with a practice in helping them become PCMH Recognized. They are going to submit their application under the 2014 standards. We have a specific question for Standard 2: Team-Based Care, Element C, Factor 4. The practice serves the Shoshone Bannock Tribes and they assess the diversity of their population. The practice explained that their primary population speaks English and/or Shoshonean/Numic. However, the language is considered a non-written language. There are only minimal phrases that could be used so it would not capture what we believe this factor is trying to achieve. What suggestions do you have for this practice if they would still like to achieve points (if possible) for this factor?

NCQA's response:

Does at least 5% of the patient population speak Shoshonean/Numic as their primary language? To meet the requirement of Element 2C, factor 4, practices must provide examples of materials provided to patients in another language unless they have fewer than 5% of patients who speak a language other than English. Since your situation is unique, I will check in with our internal policy group, but if less than 5% of your patients speaks Shoshonean/Numic as their primary language, it may not be an issue. Let me know by adding a comment below. If a practice has fewer than 5% of patients who speak a language other than English, it may indicate "NA," and provide a note in the "Support Text/Notes" field in the ISS survey tool for Element 2C. The practice evaluates language needs in Element 2C, factor 2, so that report would be used to verify the NA response and can be referenced in the note provided to explain the NA response to factor 4. No other documentation is required to support the NA response at the time of survey submission. A Yes or NA response is given credit towards the element score.

Printed materials in other languages response

I received the percentages from the practice and yes that practice has fewer than 5% of patients who speak a language other than English.

NCQA's response

As mentioned in the response to your previous question, your practice may select NA for Element 2C, factor 4 and provide documentation that less than 5% of your patients use a language other than English as their primary language.

Clarification on Eligible Entities

I have a question regarding the eligibility requirements table. One of the questions states "Does your site provide some primary or episodic care, but does not serve as the primary care practice for most of your patients?" How is NCQA defining "most"? I am working with an urgent care clinic who does act as primary care for some of their patients. They are unaware at what percentage it is at this time but are working to retrieve the reports. They are trying to determine if this recognition program is the right fit for them or if they should pursue PCMH recognition. They have a unique situation in which they own two urgent care facilities (that act as primary care for some patients) under 1 NPI in addition they have integrated behavioral health by opening their facility. I am familiar with PCMH recognition but do not know as much about the Patient Centered Connected Care and would like to direct this facility to the right program.

NCQA's response

In order for a practice to qualify for PCMH recognition, their eligible providers must provide primary care services to at least 75% of their patient population. If they do not meet this requirement, they may be eligible for other avenues for recognition, depending on the

services they do provide. Patient Centered Connected Care is available to clinics who provide more episodic care. A clinic that does not meet the PCMH criteria of providing primary care to 75% of their population may be eligible for recognition under the Patient Centered Connected Care program, assuming they meet all other eligibility criteria.

PCMH 4 B Factor 5 Documentation

Is a policy and procedure stating that care plans will be provided to the patient/family/caregiver in writing at each visit enough to meet the requirements for this factor? The EHR doesn't track that it is printed, and currently staff do not note in the record that it was printed and given to the patient.

NCQA's response:

No, practices must document that the care plan is provided to the patient in the patient's medical record. Please note, if the record review workbook (RRWB) is used as the documentation method, each factor outlined within the element requires the practice to also provide an example of how it meets the factor criteria. The patient record must demonstrate how the data was documented as required by the factor (i.e., practices must provide an example showing information documented in the patient record; an indication of "none," no information is available, does not meet the requirement).

Standard 4, Element D. Factor 4. "Alerts prescribers to generic alternatives."

I work with a practice on PCMH Transformation. They have a question regarding Standard 4, Element D. Factor 4. "Alerts prescribers to generic alternatives". This is a tribal clinic who has pharmacy within their own clinic location where patient receive all of their medications. Due to their own clinic polices and funding sources they only prescribe generic medications; therefore, their system does not alert them to generic alternatives because there is no way to select a non-generic medication I told them to explain within the ISS tool. How else should they address this factor for their NCQA reviewer? They would like to know (if possible) if this factor will be an NA for them or if they show through documentation and explanation that only prescribe generics- will they receive credit?

NCQA's response

The practice may provide reports or screenshots from the system showing that generic options are the only choice. Since patients are provided the cost-effective choice and the system is "set-up" for only generic medications, it is sufficient. It would be helpful if the practice explained their situation in the Text/Notes box in ISS so the reviewer understands the practice's set-up. There is no NA option for this factor, but from your description, it sounds as though the practice may be able to answer Yes, if they can provide the documentation.

2017 CRITERIA- Policy Procedure Clarification

PCMH or PCSP

I'm working with a women's health clinic who would like to pursue PCMH recognition. Would they pursue PCMH or PCSP recognition?

NCQA's response:

It was great to speak with you this afternoon. Per our discussion, it sounds like the Women's Health Clinic is most appropriate for the PCSP Recognition program. You are going to obtain the PCSP 2016 Standards & Guidelines on line to familiarize yourself with that program. If you determine that there are clinicians who provide full primary care services to the majority of their patients please let us know, and we can further discuss PCMH Recognition.

Ensuring True Transformation: Transformation process

I work with multiple clinics from the same organization in their PCMH transformation. Each clinic is at a different stage in their clinic transformation, with different levels of provider and clinic engagement. I am curious how NCQA ensures that clinics aren't just checking the boxes but truly transforming to become a PCMH?

NCQA's response:

For PCMH 2017, the practice will have to provide evidence for the required core criteria and their chosen electives. The evidence must be site specific, which will be reviewed by the evaluator. Depending on the criteria, some may require a report or examples and these, again, have to be site specific. In addition, the practice may elect to do a virtual check-in to show how they meet the intent of a component. The evaluator will review the evidence and make the determination if they are meeting the intent of the component. If recognized, for PCMH 2017, unlike PCMH 2011 and PCMH 2014, the recognition is good for 12 months. Each year the practice will have to show how they are sustaining their recognition and meeting the criteria of a patient centered medical home.

NCQA's response:

For PCMH 2017, new practices will have to complete the core criteria plus their selected electives. The evidence submitted will depend on the documentation requirements. Some requirements will need a report or a documented process. You can find the documentation requirements in the PCMH 2017 Standards and Guidelines. The report or examples will need to be specific to that practice site. The practice can also elect to do a virtual review or a demonstration and they will need to show how they meet the intent of the criteria. The evidence along with any demonstrations will be reviewed by your evaluator and the manager to determine if your practice is meeting the intent of the criteria. Unlike PCMH 2011 and PCMH 2014, for PCMH 2017, the recognition is good for 12 months. Each year, the practice will need to provide annual reporting to maintain their recognition and show how

they are continuing to meet the criteria and meet the expectation of being a patient-centered medical home. Hope this helps.

Accelerated Renewal from NCQA 2011 and 2014 to 2017: 2017 Annual Renewal

With the annual renew with the 2017 Standards what will clinics have to attest to? Will it be the same things each year or rotate through different criteria to ensure clinics are completing all aspects of a PCMH?

NCQA's response:

For renewing with PCMH 2017 Standards, it will be the same components. Below is a table that your practice can use if they are NOT a PCMH 2014, level 3 practice. This is our Accelerated Renewal Table for practices that are PCMH 2011, levels 1-3 or PCMH 2014, levels 1-2.

http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/PCMH%20Accelerated%20Renewal%20Table_04.13.2017_web.pdf?ver=2017-04-13-162628-743 If your practice is a PCMH 2014, level 3 practice, then please use this table located on this site. You can download it from here and it is free.

<http://store.ncqa.org/index.php/catalog/product/view/id/2751/s/pcmh-redesign-annual-reporting-requirements-to-sustain-recognition>.

Discounts Applied to NCQA 2017

Dear Corinne Bird,

You asked the following question:

NCQA 2017 discount for applicants sponsored by NCQA plus the savings before 9/30/17

I work with clinics who qualify for the 20% discount for applicants sponsored by NCQA Partners in Quality and was told they would still qualify for that discount along with the 20% discount if they enroll for the 2017 NCQA Concepts by 9/30/17.

Would the additional 20% discount come before or after the original 20% discount?

NCQA's response:

Hi Corrine, The 20% discount from Partners in Quality applies to both the additional 20% discount if you enroll before 9/30/17 as well as after, when the application fee goes up to its normal pricing.

Exceeding 12 months and 3 calls: Transformation Period and NCQA Evaluation

I know when a clinic/practice enrolls with the Q-pass they have a year until they need to be ready to submit, but I'm curious how much does the clinic have to pay if they exceed that twelve-month period? Is it a monthly fee? Is it per provider or per location? Thank you. Nicole Foster

NCQA's response:

If a clinic exceeds the 12 month period, then they can do a fourth Check-In where they pay half of they originally paid for their application fee. If they fail the fourth Check-In, then they start the Enrollment process over again and pay the full amount again.

Reverse Integration, Urgent Cares, and Specialty Clinics that include Primary Care

Reverse Integration Clinic and 75% of patients receiving primary care rule
I work with a couple clinics who have reverse integration. They started with only providing Behavioral Health Services, but have now added Primary Care. A couple of the clinics utilize the same EMR for both BH and PC, but another clinic has separate EMRs. I previously submitted a question related to NCQA's rule that a clinic must see at least 75% of their patients for Primary Care in order to be eligible for PCMH recognition rather than PCSP recognition. This was mainly posed for a clinic who is an Endocrine Specialty but added Primary Care to their clinic. Are reverse integration clinics (those who started as BH but now include PC) deemed eligible to submit for PCMH recognition? Most of the reverse integration BH clinics I work with do not fit in the "at least 75% of patients receiving primary care at the clinic" category. However, based on patients being seen on the primary care side of the clinic, they would reach the 75% level. It's just that where they have had more time as a BH provider, they naturally have more patients who fit into that category and receive BH services than they do in the PC side of the clinic. Please advise.

NCQA's response:

BH providers are not eligible for PCMH. If a BH practice includes eligible PCMH providers that see at least 75% of their patient panel for primary care services then only those clinicians would be eligible to seek recognition for PCMH.

Providing primary whole-person care to at least 75% of patients a clinic sees

In a previous question I sent to NCQA, I was informed that "Eligibility for PCMH is not based on the number of hours the practice is open but rather the fact that the practice provides principle, primary, whole-person care to at least 75% of the patients it sees." I work with a couple reverse integration clinics who started as only providing Behavioral Health services and some other clinics who started as Urgent Care Clinics who have transitioned to include Primary Care into their clinic. Would this 75% of patients receiving primary care requirement exclude these clinics from becoming NCQA recognized because the total number of patients seen for primary care (due to being a well-established Behavioral Health Clinic or Urgent Care facility with an infant Primary Care Clinic) is lower than the 75% requirement based on total number of patients seen at the clinic by including all services offered? Or, would they be able to count if 75% of their patients seen for regular medical care receive their primary care at the clinic? Thank you for clarification.

NCQA's response:

Thank you for your inquiry. The eligibility criteria pertaining to the requirement for 75 percent of patients to receive principle, primary, whole-person care includes clinicians who are providing the primary care services. For example, if there are two clinicians who are providing primary care for at least 75% of their patients they would be eligible and included on the application. If a behavioral health provider or urgent care provider provides less than 75 percent then they would not qualify. So there may be only a few clinicians at the practice who qualify and can seek recognition, which is okay. We don't require all clinicians to meet the 75% requirement within the practice for it to seek recognition but each clinician

that participates on the PCMH application do need to meet the 75% requirement in order to participate in your practice's the medical home application seeking recognition. If you have any additional questions or require further clarification, please contact Becky Best from our Policy team at best@ncqa.org.

Yes, a practice that only has one primary care clinician is still eligible for PCMH Recognition. It's important to note that the clinician who meets the eligibility criteria and sees 75% of their patients for primary care services, is the only clinician that is permitted to be included on the application.

Also, you may want to consider the practice name. If there's only one clinician at a practice who meets the eligibility and includes other specialty clinicians, the name of the practice may be an issue if its specific to the specialty such as Toledo Cardiology Center. A name like that is misleading to patients. If a practice runs into this situation, they should make sure it's clear that the PCMH recognition is specific to primary care services. For example, the practice name may appear as the following, Toledo Cardiology Center – Primary Care.

PCMH 2017 Eligibility Requirements

I work with a site that began as an urgent care site and over the past couple of years have integrated primary care to their locations. In the 2014 PCMH recognition requirements stated that eligible providers must provide primary care services to at least 75% of their population. They have not seen this same eligibility requirement stated in the 2017 PCMH Standards and Guidelines. I have assumed the eligibility requirement would remain the same. Can you please confirm (or let me know otherwise) that this eligibility requirement will apply to 2017 Standards as well?

NCQA's response

Yes, the eligibility requirements for PCMH Recognition have not changed with the publication of the PCMH 2017 standards. Eligible providers /practice sites are still required to provide first contact, continuous and comprehensive primary care for at least 75% of their patients. For more information regarding the PCMH eligibility requirements please reference the policies and procedures on page 11.

Question:

Can a Clinic who is open 2 days a week become NCQA recognized?

NCQA's response:

Yes, a practice that is only open for two days a week can seek PCMH recognition. The expectation would be that the patients can access clinical advice during all hours when the office is closed (day and evening). If this is not possible then your practice would not meet the critical factor in Element 1B, however, it's not a Must Pass Element and won't prohibit the practice from achieving recognition.

Exceeding 12 months and 3 calls

I know when a clinic/practice enrolls with the Q-pass they have a year until they need to be ready to submit, but I'm curious how much does the clinic have to pay if they exceed that twelve-month period? Is it a monthly fee? Is it per provider or per location?

NCQA's response:

If a clinic exceeds the 12 month period, then they can do a fourth Check-In where they pay half of they originally paid for their application fee. If they fail the fourth Check-In, then they start the Enrollment process over again and pay the full amount again.

Pre-validation (Epic)

We have read the "PCMH Letter of Credit Approval/Transfer Credit Summary" that gives a brief description of Fully Met, Partially Met, and Practice Support. However, as we prepare to commit and QPASS, we are hoping for a bit more clarification. >> If a criteria is Fully Met, does that mean that during the check-in the criteria (whether core or elective) is automatically credited and will not be discussed in any manner? Or should we be prepared to at least discuss the topic? >> Similarly, if a criteria is Partially Met, what does that mean? What 'part' is met and what 'part' is not met? In what way do we need to be prepared for the check-in? How do we know what we need provide (vis-à-vis evidence and/or discussion) in order to receive meet the part of the criteria that is not pre-validated? >> And finally, what does Practice Support mean to us? Again, as we prepare to commit, obviously we need to know what will be asked of us during the check-in. If our EHR 'supports' a particular criteria, does that mean that the criteria (or that 'part' of the criteria) is actually fully met or partially met?

NCQA's response:

Once you upload the HIT Implementation letter, the system will designate the appropriate credit to the criteria. The practice will be able to see the credit received and not received. As, a reminder the practice does not have to submit documentation for fully met and partially met credit. But the documentation must be available if audited. Also, here are the definitions of eligibility: Fully Meets Criteria: Criteria eligible for the "Fully Meets Criteria" designation allow vendors to convey credit without further documentation on behalf of any practice using the vendor's products. If the vendor supports some features of these factors, but the practice must act to meet the factors' intent, the vendor may achieve "Partially Meets Criteria" designation for the criteria Partially Meets Criteria: Criteria with the "Partially Meets Criteria" designation require the vendor's solution to demonstrate that it fully meets one or more evidence components of the criteria. Practices are excused from providing a specific piece of evidence for criteria with this designation. A vendor receives a "partial credit" designation when a Health IT solution demonstrate it provides some of the required evidence components specified for that criteria. Practice Support: When a Health IT solution demonstrates aligned functionality that significantly supports a practice in meeting NCQA criteria-level requirements, it receives a "practice support" designation for these criteria.

Pre-validation

I work with a clinic who received their pre-validation letter from their EHR vendor. One of the fully met criteria is AC-08 using a portal. This clinic has the capability with their EHR to have a portal but isn't currently using it. Would they still get that pre-validation credit from NCQA? Another example of this is KM-03 this clinic does PHQ-9 screenings, but doesn't use the pre-made templates in the EHR. This is a fully met criteria but they don't use the EHR to satisfy it. Will they have to submit additional information ie: documented process and evidence of implementation because it's fully met.

NCQA's response:

The practice should only use auto-credit for those components and criteria that are being used. If a practice selects that it meets a component that was obtained via pre-validation and is audited, that could result in the practice losing its recognition.

HIT Prevalidation for PCMH 2017

Could you tell me when we will know which EHRs have pre-validation credits for the PCMH 2017 recognition.

Status: Closed
Created: 06/14/2017
Modified: 06/21/2017
Case: 00149658

Answer

Hi Kim: Thank you for your inquiry. It was a pleasure speaking with you this morning about PCMH 2017 vendor prevalidation. You asked about the status of the following 3 vendors: 1) athenahealth now has PCMH Prevalidation credit for both PCMH 2014 and PCMH 2017 2) Practice Fusion just recently received prevalidation for PCMH 2014. We will be contacting them re: PCMH 2017 shortly. 3) Centricity is prevalidated for PCMH 2014 and was sent information re: an opportunity to transfer eligible credit to PCMH 2017. Please contact athenahealth for more information re: their prevalidation. Please check back with us later re: any updates on the other 2 vendors.

Subject Areas

Programs
Application/Survey (Recognition)
PCMH - Patient-Centered Medical Home

Comments

Jean Rossi said:

Jun 21 2017

Hi Kim: I tried to call you this morning after not hearing back from you re: my note below. I left a VM on your phone. Please call me at 202 955 3542 or send me an email at rossi@ncqa.org or respond via this message re: what vendor(s) you are inquiring about. Thanks, Jean Rossi

Check-ins/components/minimum/maximum

I just received a copy of a message sent to [possibly a facility who has completed initial Q-PASS?]. The message announced (among other things) minimum and maximum "components" allowed during each of the three check-ins. What is the definition of a "component?" >> Also, why the restriction? I thought the recommended path for this new design was for the submitting clinic to complete Q-PASS when they feel they are completely ready to be reviewed. If a facility thinks they have dotted all the i's and crossed all the t's, (depending on the definition of "component") wouldn't the check-in entail more than 70 "components?"

NCQA's response:

A component is an item of evidence. For example AC02 requires a Documented Process and Evidence of implementation, so those are two components. Each are represented as their own component item in Q-PASS but you need to meet both to receive credit for AC02 criterion. The max/min varies by check-in. For the first one there is a max of 70 and min of 30. That is to make the virtual session productive but also not too overwhelming. We noticed that some practices were trying to do all their criteria in one check-in, which is misleading as the check-in is only 2 hours. The min is set in order to prevent practices from checking in too few. Check-in #1: Minimum 30, Maximum 70 Check-in #2: Minimum 5, Maximum 80 Check-in #3: Minimum 1, Maximum N/A

QPASS component count 02/23/18

This is a follow-up question to closed case 00177731. (I could not utilize your follow-up procedure as my question is more than 500 characters.) I understand that a "component" is defined as proof of the Documented Process or proof of Evidence of Implementation, with each item considered 1 component. Please clarify: If the criterion is sub-divided into A,B,C,D,etc. (e.g., KM02,CM01,CC01) and each sub-division of the main criterion requires its own documented process (or evidence of implementation), is each piece of evidence counted as 1 component? In other words, if 'A' has a DP & an EI, but 'B' & 'C' must be proven with a separate DP & EI, and 'D' requires yet another DP & EI ... is the component count 2? Or 6? For the KM cores, the component count has the potential to be anywhere from 16 to over 50.

NCQA's response:

Like I mentioned it will depend on the criteria but in your example KM 02 there are 9 items listed A-I, so each of those has an evidence of implementation component associated plus one additional component for the documented process, totaling 10 components. For CC01 there are a total of 6 components as they are group a bit differently in Q-PASS, see below. For CM 01 there is only one component as only a protocol is required that would group the categories the practice selects, Identifying Patients for Care Management - Protocol, Components for CC01 Lab and Imaging Tests: Flagging Abnormal Results - Documented Process Lab and Imaging Tests: Notification of Normal and Abnormal Results - Evidence of Implementation Lab and Imaging Tests: Notification of Normal and Abnormal Results - Documented Process Lab and Imaging Tests: Tracking, Flagging and Follow-Up - Documented Process : Lab and Imaging Tests: Tracking, Flagging and Follow-Up - Documented Process Lab and Imaging Tests: Tracking, Flagging and Follow-Up - Evidence of Implementation Hope that helps.

Q-pass update/ virtual Calls (02/24/18)

I work with a clinic who has recently enrolled with Q-pass. They received a notification talking about new guidelines going along with the virtual call. On it the following was stated. "Note: each criterion has one or more **components**" What is referring to the evidence required or the different parts of criteria? For example CC-01 it could be either 6 components if they are referring to A-F or it could be 2 components if it's referring to documented process and evident of implementation?

NCQA response:

The components refer to the evidence. For example, CC 01 has two components, the documented process and evidence of implementation.

Clarification on component counts for documentation submission (02/21/2108)

Is there a component count for criterion that has multiple sub-criteria? Is every single piece of evidence counted as a "component?" For example in KM02: What if one report provides evidence for sub-criteria A,B,D and a different report provides evidence for C,F,G? Does that count as 2 components or 6 components? Or are both reports counted as one component, since all the sub-criteria falls under a single Core criterion?

NCQA response:

The count does not look at the number of evidence/documents but looks at the number of component items. Using your example, if you look within Q-PASS you will see 10 tiles, each of those count as 1 component item. You can upload multiple documents or indicate for virtual demonstration to each. Each tile is counted as one component even though within the component it might cover multiple pieces. For KM 02 each component tile must be checked in for a check-in as each item needs to be checked off. Another example is if you look at AC01, there are two tiles so 2 components.

Discount codes

Can that code only be used once per site? Can a discount code be used on the annual reporting fee?

NCQA's response:

You can use the sponsor code for multiple sites. 2. For annual reporting, the sponsor code does not work. The lowest amount you can pay is \$120 per provider between 1-12 providers. The fees do not go lower than that. The sponsor code only works for practices that are going through the Transformation process.

Virtual check-ins (01/22/17)

Hi, I am following up on a question I had asked on January 22, 2018 regarding the virtual check and time frame for obtaining PCMH recognition. Christina Borden contact me by phone and followed up with a written response to my question on January 24, 2018. From that communication I understood that a practice could finish their PCMH recognition process within 2 check in calls and a 6 month time frame if they wanted, they would just have to understand that they are on an accelerated pace, and would have to keep up with the timeline. I work with several other Quality Improvement Specialists in the state and some have been told within the QPASS system that this is not the case and a practice are now required to check in a minimum number of components and have all 3 check in's. This notice was sent on Wednesday January 17, 2018, which was after the call I had with Christina. A copy of the notification was sent to me from my peer. Can you please clarify? We would like to make sure that the guidance we are giving practices is in line with NCQA. It is very difficult when we receive two conflicting messages.

NCQA's response:

As I mentioned on the call a 3rd check-in is not required if a practice meets the requirements in 2. The message that you are looking at is the message that went with the update of system with regards to our Max/Min requirements per check-in. 1 is mentioned

with the 3rd as the min requirement if a practice needed a 3rd check-in because we had to set a system parameter. If a practice is able to mark everything off within two check-ins a 3rd is not required.

Check in calls from Allison

I wanted to circle back to our conversation about NCQA's check in calls. I submitted another question to NCQA after our discussion to make sure we weren't getting conflicting information. Christina called me again to explain the reasoning behind the message in QPASS.

Some practices undergoing 2017 were doing two things:

Not submitting enough documentation (example: a practice submitted 5 documents) to make it "worthwhile" for their NCQA reviewer.

Some practices were trying to submit everything and get done in 1 check in call

Christina did confirm that if a practice can get done within 2 check in calls, the 3rd check in is not required. The written response is just above.

Evidence – Documented Process

Thanks for the feedback. I followed up with a second question to NCQA because I wanted to make sure I understood correctly. They confirmed that documented processes do not need to be in place 90 days prior to submitting as evidence. Below are my questions and their responses. – Amy, June 2018

Evidence of Implementation

When a clinic is going through the Q-PASS system and they are giving evidence of implementation how many examples do they need to include? I know under the 2014 clinics were only required to show one example as evidence of implementation is that still the same from 2017?

NCQA response:

Unless stated otherwise in the guidance one example is sufficient.

PCMH 2017 Evidence

If evidence used is a policy and procedure, is it required there be documentation of the approval in the minutes to kick off the 90 days? If the date appears on the policy and procedure, is that acceptable?

Answer

Hi Amy - Thank you for your question. A documented process can be a policy/procedure or a flow sheet that describes or shows how your practice completes a task as it relates to the criteria. Unlike our other programs where we required practices to have an effective date on their documented process, for our current program, PCMH 2017, we no longer require an effective date to be on your documented process. We do, however, recommend that an effective date is on your documented process, but, if it is not, credit will not be removed as long as it meets the intent of the criteria. Hope this helps.

May 15, 2018

Amy Hirtle said:

Thank you for the quick response. I wanted to make sure I understand correctly: 1) A documented process does not need to be in place 90 days prior to submitting it as evidence; and 2) A documented process does not need to be dated, but it is encouraged. I'm working with a group who is getting ready for their first check-in and is choosing which evidence to submit. They will have more evidence to submit if the documented processes do not need to be in place 90 days.

May 16, 2018

Ryan Palugod said:

Hi Amy - Yes, that is correct. If the evidence states that a documented process is needed, it does not need to be in place for 90 days prior to submitting it as evidence. It is also correct that a documented process does not need to be dated, but is encouraged. I would review the PCMH 2017 Standards and Guidelines for each of the criteria that you will be submitting to see what is required. Some criteria requires a report while others may require a documented process and a report. On your reports, please make sure you have a reporting period listed. The reporting period can come from any time frame within the last 12 months. If examples are needed, then again, the examples can come from any period within the last 12 months. Hope this helps.

I did not know NCQA changed the requirement that documented processes do not need to be in place for 90 days or more prior to submission. I also didn't realize NCQA no longer requires clinics to have an effective date on their documented processes. I checked their original PCMH 2017 info sheet on policies and procedures and the updated version that came out in September 2017, and the changes are noted there. See the screen shots below. – Corinne, June 2018

May 16, 2018

Ryan Palugod said:

Hi Amy - Yes, that is correct. If the evidence states that a documented process is needed, it does not need to be in place for 90 days prior to submitting it as evidence. It is also correct that a documented process does not need to be dated, but is encouraged. I would review the PCMH 2017 Standards and Guidelines for each of the criteria that you will be submitting to see what is required. Some criteria requires a report while others may require a documented process and a report. On your reports, please make sure you have a reporting period listed. The reporting period can come from any time frame within the last 12 months. If examples are needed, then again, the examples can come from any period within the last 12 months. Hope this helps.

Types of evidence

reported data should be no more than 12 months old.

Practices may use the following types of evidence to demonstrate performance.

1. *Documented process.* Written statements describing the practice's policies and procedures (e.g., protocols, practice guidelines, agreements or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation and provide practice staff with instructions for following the practice's policies and procedures. Written statements describing the practice's policies and procedures (e.g., protocols or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation or revision (at least three months prior to submission of the survey tool) and provide practice staff with instructions for following the practice's policies and procedures.

Types of evidence

Practices may use the following types of evidence to demonstrate performance.

1. *Documented process.* Written statements describing the practice's policies and procedures (e.g., protocols, practice guidelines, agreements or other documents describing actual processes or forms [e.g., referral forms, checklists, flow sheets]). The documented process must include a date of implementation and provide practice staff with instructions for following the practice's policies and procedures.

PCMH 2014 Corporate Survey Tool Eligible Elements

The above-referenced document lists the elements that a multi-site corporation (applying under 2014 Standards & Guidelines) could document & pass "on behalf of its individual sites." Does there exist a comparable document for the 2017 redesign of Concepts, Competencies & Criteria?

NCQA's response:

For PCMH 2017, we no longer have corporate survey tools. Instead, you will have to use one of your practices as a primary site and submit corporate data using that site. We also changed terminology. What we used for PCMH 2014 as corporate elements are now called shared component for PCMH 2017. We do have a comparable document for "corporate elements" for PCMH 2017, but these are only for practices that are a level 3, PCMH 2014 practice (sustaining) or for PCMH 2011 recognized practices/PCMH 2014 level 1 or level 2 practices (accelerated renewal). As for organizations coming in for the first time as a multi-site, we do not have a document for that yet.

Multi-site "shared components"

The response to my inquiry mentioned a terminology change from "corporate elements" to "shared components." I searched the phrase "shared components" at ncqa.org, but could not find anything related to a multi-site application under the new 2017 redesign. I am looking for a list of the "shared components." Reference page 14 of the NCQA PCMH Policies and Procedures (2017 ed, ver 1): "The multi-site application process does not allow organization-wide recognition; instead, it relieves eligible organizations from providing repetitive responses and evidence that would be the same for all sites." Can I get a list of the Criteria to which repetitive responses/evidence will be avoided?

NCQA's response:

Currently, we do not have a listing of only shared components like we did for PCMH 2014 and its corporate eligible elements. We do, however, have a shared evidence symbol which can be found in the PCMH 2017 Standards and Guidelines. An example of this would be TC 01 and TC 02 where it states that the evidence provided is sharable across practice sites. As

far as a single document that states the shared components, a document of that does not exist yet.

Team-Based Care and Practice Organization (TC)

What counts for TC-03

Would participation in the Idaho Statewide Healthcare Innovation Plan count for TC-03? It is a state-wide PCMH initiative that is rolled out in the seven regions through public health teams working with primary care clinics to transform to the PCMH model of care. Many of the clinics are subsequently preparing to submit for NCQA PCMH recognition.

NCQA's response:

Yes, the Idaho Statewide Healthcare Innovation Plan would be acceptable evidence to meet TC 03 because the program is external to the practice and focuses on transformation.

TC03 - involvement in external PCMH-oriented collaborative(s)

How detailed should this description be? Would a copy of the "congratulations/welcome" letter sent by a state/federal initiative to transform to a PCMH be sufficient? (see ship.idaho.gov) Or a document confirming connection to a health data exchange? (see idahohde.org) In other words, these documents, along with the web addresses, seem sufficient as evidence of participation and/or involvement. Do we need to include any other specific details, descriptions, or explanations.

NCQA's response:

The letter of participation in the initiative and something that includes information about what the program entails such as a link to the website should be sufficient. Please note, however, the evaluator may have a few questions or need clarification about the initiative or evidence which the practice can respond to during the virtual survey check-in.

TC -05

Do you have a list of certified EMRs for this criteria? Is Office Ally acceptable?

NCQA's response:

For TC-05, the practice must have an ONC Certified EHR; you can review the list of certified systems on the ONC website: <https://chpl.healthit.gov/#/search>. Based on the website, it appears 4 versions of Office Ally are certified, so you can review the detail there to identify whether your practice's system is included.

TC-05

For TC-05 in order for a clinic to receive the 2 credit points does the clinic need to complete the Risk Assessment at the provided URL (in the standards) or does the clinic just have verify that they EHR is ONC certificated. Can I get some additional clarification on TO-05?

NCQA's response:

Because security risk analysis is part of the EHR certification process, providing the ONC Certification Number for TC 05 serves as an attestation that the security risk analysis has

taken place. For TC 05 we are looking for the ID number associated with your certified EHR. This can be submitted directly into the QPASS system.

For TC-05, the practice must have an ONC Certified EHR; you can review the list of certified systems on the ONC website: <https://chpl.healthit.gov/#/search>.

TC-05 and TC-06 and AC-02 and AC-03

I work with a very small clinic in a rural town. They are mostly a one woman show. Their provider is a Nurse Practitioner and she handles everything with the exception of some billing and taking phone calls, which is done by a part-time employee not located inside the clinic when the NP is working at her other job from Tuesday-Friday. This clinic is open on Sunday (10:00am to 4:00pm) and Monday (1:00pm to 7:00pm) for routine, urgent, and same-day appointments. They are interested in earning PCMH recognition through NCQA. With that background information, I have a few questions: 1) Can they earn NCQA recognition even though their clinic only has 12 hours of regularly scheduled operation hours each week? (She is on-call all the time and has given her cell phone number to all patients in her small community, and even makes house calls). I wondered about AC-02 (Core) requiring same-day appointments for routine and urgent care appointments. She doesn't have a schedule for patients to be seen Tues-Sat, but will see them if there is a need for same-day. This Criteria is asking the clinics to provide same-day appointments for routine AND urgent care. Would she still fulfill this requirement based on having same-day appointments available on Sunday and Monday? 2) If this clinic is only open Sunday from 10am-4pm and Monday from 1pm-7pm, will this fulfill the requirement in AC-03 (Core) to provide routine and urgent appointments outside regular business hours since she has appointments on Sundays and after 5pm on Mondays despite only having appointments on those days, not all week? 3)TC-05: Do you have a list of certified EMRs for this criteria? Is Office Ally acceptable? 4)TC-06: (Core) How can this clinic complete the patient care team meetings with one employee and receive credit for this core criteria? Thank you!

NCQA's response:

1) Eligibility for PCMH is not based on the number of hours the practice is open but rather by the fact that the practice provides **principle, primary, whole-person care to at least 75% of the patients it sees**. For AC 02, the practice must show that it has same day appointments available for both routine and urgent care needs every day that the practice is open (Monday-Friday). Sunday would be considered extended hours, so it would not be necessary to demonstrate same day appointments for those days. NCQA is not prescriptive regarding how many appointments must be left open as same-day, but it should be based on patient need and demand to ensure prompt access to care. It's also up to the practice's discretion to triage patient needs appropriately. Separate slots for routine and urgent needs are not required, but rather some same day appointment that could be filled for either purpose. 2) Yes, for AC-03, the practice meets the intent by providing hours on Sunday and after hours on Monday (5-7pm). Offering after hours care is intended to expand access to patients based on their needs, so practices should consider whether the extended hours provided meet the needs of the patient population. 3) For TC-05, the practice must have an

ONC Certified EHR; you can review the list of certified systems on the ONC website: <https://chpl.healthit.gov/#/search>. Based on the website, it appears 4 versions of Office Ally are certified, so you can review the detail there to identify whether your practice's system is included. 4) If a practice only has one care team member (the clinician), it can demonstrate the process for preparing for patient visits for TC-06. The intent of the structure communication is for the practice to review the patient schedule and prepare for visits to ensure effective and efficient patient visits.

TC-06

I work with a very small clinic in a rural town. They are mostly a one woman show. Their provider is a Nurse Practitioner and she handles everything with the exception of some billing and taking phone calls, which is done by a part-time employee not located inside the clinic when the NP is working at her other job from Tuesday-Friday. This clinic is open on Sunday (10:00am to 4:00pm) and Monday (1:00pm to 7:00pm) for routine, urgent, and same-day appointments. They are interested in earning PCMH recognition through NCQA. With that background information, I have a few questions: 1) Can they earn NCQA recognition even though their clinic only has 12 hours of regularly scheduled operation hours each week? (She is on-call all the time and has given her cell phone number to all patients in her small community, and even makes house calls).

NCQA's response:

1) Eligibility for PCMH is not based on the number of hours the practice is open but rather by the fact that the practice provides **principle, primary, whole-person care to at least 75% of the patients it sees.**

TC06 Core

TC-06: (Core) How can this clinic complete the patient care team meetings with one employee and receive credit for this core criteria

NCQA's response:

If a practice only has one care team member (the clinician), it can demonstrate the process for preparing for patient visits for TC-06. The intent of the structure communication is for the practice to review the patient schedule and prepare for visits to ensure effective and efficient patient visits.

TC06

What is the definition of "regular" on this Core Criteria? Daily? Once/week?

NCQA's response:

Thank you for your question. It is up to the practice to define how often it meets and its definition of "regular" communication. The intent of this criterion is for practices to have a process in place for all care team members to communicate about patients that will come into the office to ensure proper pre-visit preparations are in place and the visit can be smooth, coordinated, patient-centered and safe. If the practice meets or communicates once a week about the list of upcoming patients for that week, it must have a process in place to re-convene and communicate about any patients that may be added to the schedule after that meeting to ensure proper preparations for all scheduled patients. The practice must provide its documented process that outlines how and how often this communication occurs, as well as evidence of the communication.

TC06 Evidence of Implementation

I have a clinic that has been advised that a photo of a huddle taking place can be used as Evidence of Implementation. I realize that the list on page 17 of the NCQA PCMH Policies and Procedures (2017 edition) is not all inclusive, but before I pass this info on to other transforming clinics, could you please confirm [that a photo of a group of people huddling will satisfy the E of I for TC06]?

NCQA's response:

No, a picture of the huddle alone would not meet the intent of TC 06. The practice must provide evidence that it has a systematic process for communicating patient care needs and preparations in advance of the patient visit to the office. While the picture would demonstrate the action, the practice must have a way to demonstrate how and what information they communicate regarding patient care to prepare for visits. This could be demonstrated during a virtual check-in by screen sharing the notes taken during the huddles. Alternatively, the practice could conduct a huddle during the virtual check-in to demonstrate the process to the evaluator. Please note that a documented process that outlines how this communication is done is also required to meet the core criterion.

TC-08

If a clinic is choosing to do TC-08 what are the credentials NCQA is looking for as the care manager? Can it be an LPN, CMA, RN? What kind of licensure is NCQA looking for?

NCQA's response:

Thank you for your question. For the elective criterion TC 08, practices are expected to have a trained staff person responsible for coordinating behavioral health care needs, but NCQA is not prescriptive regarding which care team member it is (clinician, nurse, social worker or other provider) and the practice may determine the training and skills needed to address and manage the behavioral needs of their patient population. *The PCMH 2017 requirements will be updated because NCQA is not requiring that the care manager "provide psychotherapeutic treatment directly" in order to coordinate behavioral healthcare needs for patients.*

TC-09

Does the brochure need to include everything (after-hour access, practice scope of services, evidence-based care, availability of education, self-management support and practice points of contact or does it just need some of these element?

NCQA response:

All of these items should be addressed by the practice in some way, whether it is via the website, in a brochure, or in other patient materials. The practice can use multiple methods to disseminate this information as long as it is addressed somewhere.

Knowing and Managing Your Patients (KM)

KM01

I work with a practice who may not be able to retrieve a report from their EMR for KM01. It indicates that the practice can utilize the same evidence for KM01 and KM06. If the practice cannot complete KM06, what is another way a practice can indicate that they are meeting KM01? Would a manual chart audit suffice? What parameters (frequency, number of audits, etc.) would NCQA like so they can indicate they are meeting the criteria. The practice will be able to show during the virtual review how the problem lists and how they are continuously updated at each visit. Thank you for your time!

NCQA's response:

Thank you for your question. If you must conduct a chart audit to complete the report, you may use the same methodology as the Record Review Workbook which requires at least 30 charts. The intent of core criterion KM 01 is for practices to measure and report how many patients have problem lists to ensure that this key information is documented in patient records systematically to enable optimal patient care and resource management. The time frame of the report would be up to the practice, but should include enough data to provide a representative sample of patients and be meaningful for the practice to review. If you have any further questions please do not hesitate to reach out.

KM-01 and KM-06

What kind of report is NCQA looking for on KM-01? Or if a clinic opts to use KM-06 as their form of reporting do they just need to have a list of predominant conditions and health concerns?

NCQA's response:

Thank you for your inquiry. In PCMH 2017 we have provided more flexibility for the practice to be pulling meaningful reports. As it states in the policies and procedures reported data should be no more than 12 months old. The practice should be looking at reporting periods that are meaningful to the practice and their specific population, so the practice is defining the reporting period. We also have a virtual review as part of the survey allowing us to instantly validate processes are being followed as well as have the practice clarify or explain any questions that may arise. In addition, you can also find a list of acceptable forms of evidence in the **policies and procedures on page 16**. A practice can use any of those forms unless specified under the evidence section. We have moved away from requiring specific items of documentation and specific reporting periods to allow practices to demonstrate however they can, as we believe there are a variety of mediums in which a practice can demonstrate they meet criteria and therefore, NCQA doesn't need to be as prescriptive. A practice can meet KM 01 with a report or by meeting KM 06. This means a practice can meet both criteria with acceptable evidence for KM 06 with a list of

predominant conditions or health concerns determined through analysis diagnoses or problem lists. The practice should identify predominant conditions that are specific to their patient population as each practice has a unique population that may influence how they organize resources and operations.

KM-02

I work with a pediatric clinic. We were discussing KM-02. Does the Health Risk Assessment have to cover the entire population or does asking teenagers about risky sexual behavior satisfy KM-02 E or do the providers also need to patients of young children about the secondhand smoke? In short, do the questions have to cover the entire population or it be focused on certain age groups and for every letter A, B, C, D, E, F, G, H?

NCQA response:

NCQA is not prescriptive regarding age range for evaluation, and it is up to the practice to determine an appropriate age range, but the practice should have a process in place to systematically and comprehensively evaluate its entire patient population to ensure it identifies any patient characteristics that could impact physical or mental health as early as possible in the patient's life. There may be some questions on the comprehensive health assessment that may be appropriate for a specific age range, such as the risky sexual behavior. However, there are others that may be asked regardless of the child's age, such as secondhand smoke. For young children, the practice may ask their parent or guardian to complete the questionnaire, some responses may be based on the parent's or guardian's observations. For KM 02 E, asking about risky sexual behavior to adolescents would be acceptable, but the practice may want to consider including questions about other behaviors affecting health, such as secondhand smoke exposure or nutrition or oral health, so they do not miss any important behaviors that impact health. The intent here is to capture what the practice deems important to know to have a comprehensive understanding of the patient's health. The practice must provide its documented process that outlines how it systematically collects (and updates, as needed) this information from patients. The practice should rely on evidence-based guidelines to determine the appropriate frequency to collect and update a patient's comprehensive health assessment when developing their documented process. Some items may need to be collected once during their new patient visit (i.e., communication needs, family/social/cultural characteristics, etc.), but others may need to be updated as health or circumstances change (i.e., medical history, behaviors affecting health, etc.). It is ultimately up to the practice to determine the appropriate process that best meets the need of their patient population. If the information is collected at different times, this should be included in the documented process to ensure that staff are collecting and documenting consistently. How the staff enters this information may be included as part of the documented process. In addition to the documented process, the practice must also demonstrate evidence of the documentation, which could include a report showing the frequency of documenting this information across the patient population (if the practice is capable of pulling such a report) or evidence of documentation in patient medical records.

KM-02 G AND KM-07

I work with clinics to get NCQA recognition and today while meeting with one of the pediatric clinics they had some questions about KM-0 G collecting information about social determinates of

health. Questions 1: What are some good examples relating to a pediatric population? Question 2: How is the best way to gather this information without offending the patients? KM-07 Once the practice has gathered this information what is the best way to connect those resources/ what kind of interventions are NCQA looking for?

NCQA's response:

Thank you for your inquiry. I've provided responses to your questions below. What are some good examples relating to a pediatric population? There are social determinants that are specific to kids. Economic stability can have an effect on a child's food security, housing stability and environmental conditions. For example, exposure to toxins such as lead paint or lead in the water supply could have serious effects on the development of a child. Children may live in areas where they don't have access to healthy foods or to health care services. In other cases health care services may be available but they may not have any way of getting to the appointment. In addition, social determinants of health for children can often stem from those affecting their parents. Socioeconomic status is a big one that affects both adults and children. Children in low-income households are more likely to experience respiratory illnesses, injuries, and other adverse health outcomes. Parental unemployment has also been linked with an increased prevalence of chronic illnesses, infections, and poor nutrition, independent of the financial strain associated with unemployment. Parental education and health literacy can also have a strong effect on a child's health and development. Family structure is another social determinant that can have a huge effect on a child's well-being. Looking at whether a child has two biological parents, one biological and one stepparent, a single parent, or other guardian relationship could have an influence on his or her child's health. Divorce can result in lower household income which could account for inequities in child well-being between children in single parent families and those in two-parent families. A step-family may introduce a new parent who is less inclined to invest resources and support to a child.

And lastly there's the possibility of resource dilution by which having more children could result in diluting family resources (e.g., parental time and money) and therefore may result in less positive child outcomes.

Poor parental mental health due to stress for example might adversely affect parenting behaviors, thus also resulting in less positive child health outcomes. A stressed parent may focus more on pressing needs such as finances, nutrition and housing, and less on health maintenance and disease prevention strategies for the child.

How is the best way to gather this information without offending the patients? This information could be collected in conjunction with other health information gathered for the child's comprehensive health assessment. Some areas may be more apparent than others and may not require specific questions if they can be observed by the clinician such as socioeconomic status if the family is on Medicaid. Family structure and parental education could be collected using questions from a pre-visit information form. A parent's education level will be important information not only to determine any social determinants of health but also to assist in assessing the health literacy of a parent. There may be some questions such as those surrounding environmental conditions of the area/housing that the clinician may need to ask more pointed questions about in order to assess any effects they may have on a child's health and development.

Please note, NCQA is not looking for practices to have a complete list of every possible social determinant of health that needs to be checked off for each patient. The purpose of this item within the criterion is to collect information on areas that may be influencing/affecting a child's health and well-being, many of which can probably be observed by the clinician or assessed using some questions that are prompted by what's being observed.

For KM 07

NCQA is looking for the practice to implement some type of intervention to help address issues identified using the data collected in KM 02. For example, if access is an issue because patients can't get to the practice for care, then an intervention the practice could implement may include providing and/or assisting in setting up transportation to and from care appointments. The intervention doesn't necessarily have to be provided by the practice but they do need to collaborate with any other community resource in providing and/or arranging any type of interventions/support services. I realize this is a lot of information, so if you have any additional questions, please don't hesitate to contact us.

KM02

Is there a frequency expected for providers to administer this assessment? If their standard practice is to do a yearly health history, would that suffice with this criterion?

NCQA's response:

NCQA is not prescriptive regarding the time frame for collecting and updating the comprehensive health assessment information required in KM 02. It is up to the practice to determine the appropriate time frame based on evidence-based guidelines (when applicable), and the details about how this information is reviewed, discussed and updated should be outlined in the practice's documented process so that the staff knows the process and is able to implement it consistently and systematically across patients to ensure updated, pertinent, useful and patient-centered information in the medical record. In addition to the documented process, the practice must demonstrate how it implements the process and documents this information during the virtual check-in.

KM02

On KM 02 the criteria states that the comprehensive health assessment needs to include all categories A- I. In category G, several examples are listed. The examples seem to be divided into 2 categories "conditions in a patient's environment" and "risk factors". Are practices required to include questions that address all the examples listed? Is there a standard of how many questions need to be asked in order to meet this section of the criteria?

NCQA's response:

Thank you for your inquiry. For KM 02G, practices are not expected to capture every example listed under the guidance. The list is provided to provide some examples. NCQA is not prescriptive about how many questions around social determinants of health your practice needs to ask. It is up to the practice to determine what social determinants of health are important to collect for your patient population. KM 02 requires a documented process and evidence of implementation. The intent of KM 02 is to collect information at the patient level on the various items outlined within the criterion. The evidence required for KM 02 does not require a report or chart review, therefore, NCQA is not looking for the

practice to measure each item within the criterion. The practice should outline how it collects and documents this information in its documented process. For evidence of implementation, the practice can determine how best to demonstrate its process. For example, the practice may share several examples to demonstrate where this information is documented in the patient record during the virtual review. In addition, you can also find a list that outlines the acceptable forms of evidence in the policies and procedures on page 16. A practice can use any of those forms unless specified under the evidence section of the criteria. If you have any additional questions, please don't hesitate to contact us.

KM02

I have 2 questions regarding KM criteria. KM02 includes a developmental screening tool but NA for practices with no pediatric populations. A practice that I work with has patients that are manually assigned to them by a health plan. They have 2 pediatric patients that attributed to their practice. Even though these patients are attributed to them by default the practice refers them out to primary care providers. The pediatric patients may still be seen by them because they also offer urgent care services. Could this practice demonstrate their process for collecting the developmental screenings from the pediatric practice rather than implementing this tool because of the attribution?

NCQA's response:

Thank you for your questions. KM 02: Have those patients (or rather families/caregivers) selected that practice as the patient's primary care provider, or do those patients have another provider as their primary care provider? It sounds like the latter based on the question. If those patients go to the practice for their primary care services, we'd expect that the screening is done; however, if the patient has a primary care provider they've selected elsewhere, I don't think the patient would truly be considered empaneled at the practice. The goal is for this assessment to be done for patients empaneled at the practice. This also seems like a good opportunity for the practice to reconcile your patient panels with the health plan that's attributing the patients to you if you truly aren't seeing those patients for primary care (AC 14).

KM02G

Reference KM02. Specifically G-"Collects information on social determinants of health." There are so many social determinants. How many does the clinic need to "collect information on"? Is PCMH looking for any specific questions?

NCQA's response:

For KM 02 G, the practice should consider all potential social determinants of health when collecting information on patients; however, NCQA is not looking for practices to have a complete list of every possible social determinant of health that needs to be checked off for each patient. The purpose of this item within the criterion is to collect information on areas that may be influencing/affecting a patient's health and well-being, many of which can probably be observed by the clinician/care team or assessed using some questions that are prompted by what's being observed. Each practice is unique and so there may be social determinants of health that are more common to your patient population than others. Therefore, the practice may want to consider identifying common areas and develop standard questions to ask patients. However, please note, it's also important that the practice doesn't limit the assessment to just the most common areas and ensure all relevant information is documented in the patient's medical record IF the care team observes red

flags that point to other social determinants not commonly seen within your patient population.

KM-02 I

For the advanced care planning does the clinic need to have the advanced care planning on file or does the clinic just need to ask if their patients have advanced care planning in place?

NCQA response:

It is beyond just asking if they have advanced care planning in place, the discussion from the advance care planning should be documented. KM 02I focuses more on the ongoing process where the practice assesses the patient's preferences and the trajectory of care if the time comes when the patient cannot speak for themselves. Advance care planning can be done whether the patient is well or sick and should be updated as circumstances change. Please note that it's important to remember that we're looking for practice's process regarding how this information is collected as well as how it's documented in the system for KM 02. For evidence, NCQA is looking for the practice's documented process and evidence of implementation which could include demonstrating the information from these advance care planning discussions are documented in the patient's record during the virtual review. KM 02 does not require a percentage to meet the criteria so it would make sense for the practice to prepare evidence of a patient(s) who did not decline to participate in advance care planning discussions in addition to providing its documented process. We want to see that the information is documented from these advance care planning discussions AND is reviewed regularly and updated as needed. NCQA is not prescriptive about how often the advance care plan is updated. It is up to the practice to work with the patient to ensure it is up to date based on their own process. Documentation of advance care planning discussions or the presence of advance directives itself would demonstrate that advance care planning has been conducted, but again please note, having a completed advance directives is not required. For more information on advance care planning you may want to review this site as it provides a good definition and subject areas for discussion <http://www.nhpco.org/advance-care-planning>.

KM-03

I work with a pediatric clinic. They have implemented the PHQ-9 in their practice. I know that on KM-03 it says they need to administer a depression screening tool for 12-18. When the clinic starting they would give 12-18 years old the PHQ-9. Most of the time the patients 12 and 13 years old didn't understand the questions or would have their patients fill it out. The practice has changed and gives them only to 14-18 years old. Are they still meeting the KM-03 requirements?

NCQA Response:

It wasn't clear from your inquiry whether you've modified the age of adolescent depression screening based on the practice's experience alone or in combination with evidence-based guidelines that direct adolescent depression screening be started at 14 years of age. If the age range of screening was modified based on evidence based guidelines, it would be acceptable. If not, then no, the practice would not meet the intent of KM 03. Two sources we frequently point practices to are AAP's Bright Futures and USPSTF, both recommend depression screening for adolescents ages 12 to 18. The practice may use the modified PHQ-A, which is very similar to PHQ-9.

KM04

I have a question regarding behavioral health screening assessments. This criteria more specific than the related factors 3C6 & 3C7 in 2014 standards. In discussing these screenings with a practice yesterday the question of "who" delivers these screenings came up. The practice is trying to determine the most appropriate workflow and with the criteria it doesn't specify if the screenings can be conducted by behavioral health providers or if they need to be given by the primary care provider. Their past approach has been- the primary care provider would send their patient (if needed) to behavioral health to conduct these screenings. Is NCQA prescriptive with this criteria? Are they looking for the PCP or BHP to deliver the screenings? As always, thank you for your assistance!

NCQA's response:

Thank you for your question. PCMH 2014 3C6 and 3C7 align with PCMH 2017 KM 02E and KM 02B, respectively. The intent of KM 02 is to collect information at the patient level on the various items outlined within the criterion. The practice should outline how it collects and documents this information in its documented process. For evidence of implementation, the practice can determine how best to demonstrate its process. For example, the practice could share several examples to demonstrate where this information is documented in the patient record during the virtual review. KM 04 focuses on evaluating whether behavioral health screenings/assessments are conducted in the primary care setting so it does not require that the screenings be conducted by behavioral health providers. However, it should be done by primary care practice staff with proper training (as defined by the practice) to accurately diagnose, treat and follow-up, as needed. It's up to the practice to determine its process for screening its patients for behavioral health issues. The practice should determine the appropriate population for screening behavioral health issues and consider who conducts and at what point it's most meaningful to initiate a screening and/or assessment based on its patient population and evidence-based guidelines. The practice should outline how patients are identified for a particular screening or assessment such as an anxiety screening in its documented process. Please note, each item listed under KM 04 requires the use of a standardized screening or assessment tool. In addition, this criterion requires both a documented process and evidence of implementation. KM 04 requires the practice to provide (1) evidence of implementation AND (2) a documented process for each item. The practice should have a process to routinely screen patients, however; the frequency at which they are conducted is up to the practice to determine. The documented process should also include what follow-up occurs for positive screens.

Further explanation on KM05

Can you explain the intent further? Is the practice expected to assess oral health needs for every patient? If a practice assesses oral health needs and provides a fluoride varnish application for their pediatric patients, but provides information for local oral health partners to all patients, is this enough to fulfill the intent? I know you are always very busy and have lots of questions to answer.

NCQA's response:

KM 05 is looking for practices to assess the oral health needs for patients across the practice by providing oral health services or helping to coordinate referrals to oral health providers for needed services. This doesn't mean you have to do an assessment on every patient. If the

practice has specific protocols in place to provide fluoride varnish application to pediatric patients but not adult patients, that's okay. The practice doesn't have to provide the same services to all age groups. For adults, the practice may provide resources and referrals to patients based on their history. For example oral health is especially important for diabetic patients so, the practice may implement protocols to provide resources and/or referrals to patients with a diagnosis of diabetes. In addition, please note, providing information regarding local health partners alone would not satisfy KM 05 but would be appropriate for KM 23.

KM07

The practice I work with is unable to pull a report as evidence for this criteria. I understand that a manual chart audit of at least 30 patients could be utilized instead of a report along with the evidence of implementation. Can you please provide clear guidance on the best way to conduct the audit for this section? All patients are asked SDOH questions as outlined in KM02, but not all patients respond yes to require the intervention. If the practice were to have 2 columns on the audit, one that asks if the patient was assessed for SDOH needs and one column that asks if an intervention was provided, would that be sufficient? Or does NCQA need to require that 30 patients receive the intervention for the audit?

NCQA's Response

For KM 02, although all patients must be screened, it is not expected that all patients will respond "yes". The practice would still need to record that the question was asked and that the patient responded no. The intent of elective criterion KM 07 is for the practice to show how it monitors social determinants of health at the population level for its patient population and also how it uses that data to address and assist in overcoming those social determinants of health. This criterion goes beyond providing the percentage of patients with social determinants of health documented in the medical record; the report identifies a social determinant or a group of social determinants that the practices then can implement a care intervention on. For KM 07, your suggestion of using 2 columns on the audit assessing if the patient was assessed and if the intervention was provided could be used as a manual chart audit. In addition to the chart audit, the practice would also need to provide evidence of implementation demonstrating the intervention and how it addresses the SDOH.

KM-07

KM-07 Once the practice has gathered this information what is the best way to connect those resources/ what kind of interventions are NCQA looking for?

NCQA's response:

For KM 07, NCQA is looking for the practice to implement some type of intervention to help address issues identified using the data collected in KM 02. For example, if access is an issue because patients can't get to the practice for care, then an intervention the practice could implement may include providing and/or assisting in setting up transportation to and from care appointments. The intervention doesn't necessarily have to be provided by the practice but they do need to collaborate with any other community resource in providing and/or arranging any type of interventions/support services.

KM-08

Can I get some additional clarification on KM-08. What kind of report is expected? What are some examples of doing this? How can does a clinic prove the education given is education level appropriate?

NCQA response:

KM 08 is looking for the practice to evaluate the communication preferences and health literacy needs of its patient population based on information collected. You should first identify the sub populations in a report demonstrating the data used to evaluate the practice's patients communication needs and preferences. This may require information such as languages spoken, health literacy levels, and/or other communication data. This criterion also requires evidence of implementation demonstrating the materials created for its population takes into account the health literacy of its population and how the population prefers to receive information. This may include some of the different materials used to communicate with your patients, such as mail, email, phone scripts, etc. The evidence-based materials that can be provided in any language would be appropriate. Ultimately, the intent of this requirement is that the practice can demonstrate the data used to assess the patient population and then use the analyzed data to tailor the educational materials to ensure patient understanding. The Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit (<https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html>) is a helpful resource to help ensure you communicate helpful information to your patients in an understandable way.

KM09 & KM10

Please clarify the definition of "assess." Each of these Cores requires a report as evidence. Does this report just need to show that race, ethnicity, diversity, language needs, etc. has been collected for 'x%' [numerator/denominator] of patients? Does the report need to be broken down to percentages of specific races, ethnicities, languages, etc.? What sort of report is needed to prove these characteristics have been "assessed." Proving the collecting of the data is one thing. What do you need for the "assessing" portion of the criteria?

NCQA response:

For KM 09 and 10, the intent of assessing the specified criteria related to your patient population is to ensure the practice is seeking to meet the needs of patients served by understanding their populations unique characteristics and language needs. KM 09: Data may be collected directly from patients (by pulling an EHR report) or the practice may use data on the community served. A report demonstrating the race and ethnicity breakdown of your patient population would meet the requirement for items 1 and 2. For the third item, the practice should identify another aspect of diversity that's meaningful to the practice that could help to identify social determinants of health within its patient population. For example -Providing a report with patient zip codes in order to help identify high Medicaid areas would meet the requirement. For KM 10, As with KM 9, data may be collected directly from the patients (by pulling a report from your EHR), or may be data pertaining to the community served by the practice. The practice should provide a report that includes a breakdown of the various languages spoken by the population or the community. NCQA is not prescriptive regarding how the practice evaluates the language needs of its population.

We're just looking for the identification of the patient populations spoken languages. A breakdown of the languages represented in the population is sufficient to meet this criterion.

KM12

Can a practice utilize the same outreach material to meet the evidence requirements for immunizations and patients not recently seen by the practice? The practice has a reminder postcard they are sending to their patients, but in order to remain HIPPA compliant they refrained from creating a separate card specific to immunizations. The card states "Reminder, it's check-up time- make an appointment at your earliest convenience. The postcards are being sent to two separate patient lists.

NCQA's response:

Yes, the practice may utilize the same outreach material for proactive reminders for multiple services/purposes. However, the specific service(s) or purpose(s) must be identified. Using a generic postcard stating "it's check-up time" would not be sufficient. If there are privacy concerns to sending proactive reminders via postcard, the practice may consider using other methods of outreach, such as a letter, telephone call, message in the patient portal, or other alternative. The intent of KM 12 is for practices to proactively identify patients in a list/report and remind them of needed services. The practice must demonstrate its list generated for reminders as well as outreach materials. It is up to the practice to determine the best methods for reminding patients in advance of these services, and the outreach materials provided as evidence must demonstrate the process for outreach. Waiting to provide the reminder until the patient is in the office would not be acceptable since patients who do not have a office visit may miss out on important service reminders. The practice must demonstrate that it conducts this outreach for 3 of the 4 listed categories (preventive care, immunizations, chronic or acute care, patients not recently seen). For each category (A-D), practices must demonstrate two pieces of evidence: (1) a list or report of the patients identified using population health data as needing the specific service identified, and (2) examples of the outreach materials that demonstrate how the patients are reminded of these specific upcoming services. For category C only, if a practice meets KM 13, it meets the requirement; so for this reason the documentation for C is either (1) the report/list and outreach materials, OR (2) meeting KM 13. If a practice meets category C, it must also demonstrate how it meets two more categories (A, B or D) by demonstrating its report/list and outreach materials for each.

KM-13

I work with a practice who would like to use their Truven scores to obtain credit for KM13. I want to verify if these reports/scores will meet the intent of KM13. In the past NCQA hasn't accepted reports from just one payer unless they make up 75% of the practice population. Is this true for KM13 as well? Here is more information on Truven that Blue Cross uses. Eventually, Medicaid will be using the same methodology but that won't happen until 2019. Truven is a methodology that Blue Cross uses to evaluate how well providers are doing relative to their peers locally and regionally. They use claims data to compile a scorecard for each provider and the clinic. Providers are given an adjusted cost score taking into account the complexity index of the patient population attributed to them. The complexity index includes an adjustment for patient's age, gender, and a risk score that takes into account any co-morbidity conditions. They can drill down on individual

episodes of care to determine if a visit was coded to the highest level of complexity, etc. Truven has a disease staging mechanism that reflects the level of acuity for a patient's illness based on five stages: 0 – History or suspicion of, or exposure to disease 1 – A disease with no complications 2 – The disease has local complications 3 – The disease involves multiple sites or has systemic complications 4 – Death Reimbursement is tied to performance. There are three fee schedules. If a provider/clinic has an adjusted cost score of 0.90 or less (so they are essentially performing at least 10% better than their peers), they qualify for the premier fee schedule. I hope this explains it clearly.

NCQA's response:

It was a pleasure to speak with you over the phone. Typically, physician P4P programs do not meet the intent - although there may be benchmarks to compare to, they are not recognition programs and do not include public reporting of site-specific measures. For KM 13, NCQA is looking for the practice to participate in an external recognition program that assesses the practice's performance, using a common set of specifications to benchmark results. The external recognition program should also publicly report results and have a process to validate measure integrity. If you find out additional information about Truven and feel it meets the criteria to meet KM 13, please reach out so we can discuss further.

KM-13

What does HSRP and DRP stand for, and how does a clinic get that recognition for 75% or more of their eligible clinicians? How do they demonstrate excellence utilizing evidence-based care guidelines?

NCQA's response:

HSRP and DRP are the Heart Stroke Recognition Program and Diabetes Recognition Program respectively. They are other recognition programs through NCQA. You can find more information about these programs following the link below:
<http://www.ncqa.org/Programs/Recognition/Clinicians.aspx> For KM 13, NCQA is looking for the practice to participate in an external program that assesses the practice's performance, using a common set of specifications to benchmark results. The external program should also publicly report results and have a process to validate measure integrity.

KM 14-15

At my NCQA training with Bill Tulloch I thought be mentioned that KM-14 would have a records review workbook available, is that true? Does that also mean there is a RRW for KM-15?

NCQA response:

No, while a Record Review Workbook was an option for medication management requirements in PCMH 2014, the Record Review Workbook for PCMH 2017 does not include options for reporting criteria in KM. However, if for any reason a practice cannot run a report for KM 14 and KM 15, it would be acceptable to do an audit of patient medical records that is representative of the patient population to generate reports to demonstrate meeting the percentage thresholds required by the factors. It would be up to the practice to determine the appropriate time frame for sampling that would ensure a representative

sample of patients to demonstrate that this is done systematically for all patients taking medication.

KM 16 & 17

If a practice does both of these activities but their EMR has no way of tracking the information so a report could be developed. If they had developed and implemented a policy to conduct manual chart audits on a regular basis (3/6/12 months) and had records of the chart audits, would NCQA consider counting this as evidence?

NCQA's response:

In regards to KM 16 and KM 17 a report is required as well as evidence of implementation. NCQA doesn't require the report to be electronic, so if the practice is not able to use a report from its electronic system, it could develop its own sampling methodology or chart audit to validate it meets the threshold for more than 50%. The report piece of the requirement is to validate practices are capturing the information consistently. Therefore, if your practice can demonstrate its consistently capturing the data through another report method it would be acceptable

KM02 and KM16 & KM17

KM02 includes a developmental screening tool but NA for practices with no pediatric populations. A practice that I work with has patients that are manually assigned to them by a health plan. They have 2 pediatric patients that attributed to their practice. Even though these patients are attributed to them by default the practice refers them out to primary care providers. The pediatric patients may still be seen by them because they also offer urgent care services. Could this practice demonstrate their process for collecting the developmental screenings from the pediatric practice rather than implementing this tool because of the attribution? KM 16 & 17 If a practice does both of these activities but their EMR has no way of tracking the information so a report could be developed. If they had developed and implemented a policy to conduct manual chart audits on a regular basis (3/6/12 months) and had records of the chart audits, would NCQA consider counting this as evidence?

NCQA's response:

KM 02: Have those patients (or rather families/caregivers) selected that practice as the patient's primary care provider, or do those patients have another provider as their primary care provider? It sounds like the latter based on the question. If those patients go to the practice for their primary care services, we'd expect that the screening is done; however, if the patient has a primary care provider they've selected elsewhere, I don't think the patient would truly be considered empaneled at the practice. The goal is for this assessment to be done for patients empaneled at the practice. This also seems like a good opportunity for the practice to reconcile your patient panels with the health plan that's attributing the patients to you if you truly aren't seeing those patients for primary care (AC 14). KM 16 & 17: In regards to KM 16 and KM 17 a report is required as well as evidence of implementation. NCQA doesn't require the report to be electronic, so if the practice is not able to use a report from its electronic system, it could develop its own sampling methodology or chart audit to validate it meets the threshold for more than 50%. The report piece of the requirement is to validate practices are capturing the information consistently. Therefore, if your practice can

demonstrate its consistently capturing the data through another report method it would be acceptable

KM-18

I'm working with a clinic that used the Idaho state controlled substance database. For KM-18 what kind of evidence of implementation is NCQA looking for? Individuals at the clinic have log ins to the database. Can the clinic show how they retrieve applicable information?

NCQA response:

The simplest method of demonstrating evidence of implementation would be for the practice to show how they log into and reference the database during the virtual check-in.

KM-19

Can I get some clarification on KM-19? If a clinic uses Surescript or using a data exchange automatically fulfill this criteria? How would they show the evidence of implementation?

NCQA response:

For KM 19, if a practice can demonstrate use of a system, like Surescripts, to receive prescription claims data across payers that could meet the intent of the criterion. To demonstrate evidence of implementation, they would need to show the system and how they can access patient claims data during the virtual check-in via screen sharing

KM-21

On KM-21 is there a suggested way that clinics can pull reports on needed community resources? Also, how do they show that report to NCQA?

NCQA's response:

KM 21 does not require a report. The evidence required is a list of key patient needs and concerns. The community resources should be identified based on the patient information collected and assessed.

KM-21

I can get some additional clarification on KM-21. How is a clinic supposed to assess the top needs and concerns. Can this be done through diagnosis codes? Could this be through asking providers and nurse for their top referrals or needs? Does this have to be quantifiable by a number or score or can it be more objective?

NCQA's response:

This criteria is looking for the practice to assess a variety of specific needs. In order to determine which community resources are needed most by the patient population, the practice should assess the information they've already collected on their patients. Information collected in KM 01, KM 02, KM 06, KM 07, KM 08, KM 09, and KM 10 can all be useful information for conducting its assessment. While it may be helpful for the practice to

have a documented process in place to use patient information to identify key community resources needed by their patients, it is not required to meet KM 21 and a quantifiable description is not necessary either. Once these needs are assessed, the practice can make a list of resources to meet these needs to satisfy KM 26.

Clarification on KM21

Can you explain further or provide an example? This seems similar to some of the following criteria in the KM section. Is this criteria just supposed to be in a "single list" form? Could a practice use a "needs assessment" of the area they used to get their clinic funded?

NCQA's response:

If you are familiar with the PCMH 2014 standards and guidelines, KM 21 is very similar to Element 4E, factor 6. NCQA is just looking for a list of key community resources identified by the practice based on the needs of its patient population. In order to determine which community resources are needed most by the patient population, the practice should assess the information they've collected on their patients. Information collected in KM 01, KM 02, KM 06, KM 07, KM 08, KM 09, and KM 10 can all be useful information for conducting its assessment. In regards to your question about a "needs assessment" of the area a practice used to get their clinic funded, how old is this information? If it's more than 12 months old you'll want to use more up-to-date information collected on the patient population. Also, I'm not sure I understand what you're referring to when you say "area". Are you talking about the region, locale, of the practice? If so, it sounds like this may be information on the surrounding community and not specific to the practice's patient population. These resources should be identified using the information collected on the practice's patient population. If the information is specific to the patient population, then it would be part of the overall patient information available to practice to use when conducting its assessment. Just be sure that you're basing the assessment on recent patient data.

KM-21 Reporting

On KM-21 (Core), is there a suggested way that clinics can pull reports on needed community resources? Also, how do they show that report to NCQA?

NCQA's response:

KM 21 does not require a report. The evidence required is a list of key patient needs and concerns. The community resources should be identified based on the patient information collected and assessed. If you have any additional questions, please don't hesitate to contact us.

KM-22

I need a little extra clarification on KM-22. If a clinic gives patients a brochure or information about their new diagnosis does it meet the intent of the criteria? How would a clinic show their evidence of implementation? Would showing what handout they give and when they would give them out meet the evidence requirement?

NCQA response:

Yes, brochures, websites or other materials that include resource lists, tools, educational events or other resources that can help the patient population better manage their care (based on data collected in KM 21) would meet the intent. The practice can show examples of materials provided as evidence of implementation.

KM 22, 23 and 25

Regarding KM 22 & KM 23, can a practice utilize their oral health resources and educational for both criteria? Or do they need to have 3 different resources that doesn't include oral health for KM 22? Regarding KM25 What all counts towards school engagement? A practice I work with presents at our local grade schools and college. There is no formal agreements in place, but a school based presentation is scheduled ever quarter (variety of topics pertaining to children and college students) Would this count for this criteria. If it does what type of evidence could they use? Would a schedule and presentation materials suffice?

NCQA's response:

KM 22 & 23: Thank you for your question. No, practices cannot use the same resource for two criteria in this case. For KM 25: The intent in developing and including KM 25 as an elective criterion in PCMH is for the practice to help to address healthcare in the community. The intent of this requirement is for continuous collaboration around patient care, rather than just a one-time collaboration. It sounds like the presentations you outline meet the intent of the requirement, but you will need to demonstrate the relationship between the practice and other organization(s) is continuous and any evidence/agreements to support meeting the requirement should describe how the two (or more) entities work together to improve patient health, access to care and resources. Showing an example of the presentation schedule and materials would be a good idea.

KM-24

Can I get some additional information? If a clinic gives their asthma, diabetes and behavior health concerned patients a questionnaires' with open ended and thought provoking question. They are given at wellness and medication refill appoints. Their intent is to start patients thinking about what they want and then the provider reviews this questionnaire and together they come up with a treatment plan. Does this satisfy KM-24?

NCQA response:

No, questionnaires would not meet KM 24. The intent of KM 24 is for practices to demonstrate use of shared decision-making aids; these are informational resources to use with patients to educate/describe evidence and information comparing treatments for conditions that have multiple treatment options. Examples of shared decision-making aids can be accessed here: <https://shareddecisions.mayoclinic.org/> Please note that this criterion is elective and not required for recognition, so if use of these tools is not pertinent to the practice's patient population or if the practice does not currently use these tools with patients, it may select other criteria to meet the 25 elective credits required for recognition. For KM 24, practices must demonstrate at least three different decision aids or tools that are used by the practice to have these conversations with patients. Specific patient examples would not be required for this criterion

KM 25 Follow-up Question:

I submitted a follow up question to KM25 and received an email stating it was closed, but didn't receive an answer to my question below. I apologize, but I'm circling back to KM25 to identify other ways a practice may meet this criteria. I'd like to ask for further clarification on "intervention agencies" and "social services". Will NCQA accept Public Health fitting into these categories? We have several programs in which we work with clinics to help improve access, resources etc. for patients with chronic diseases. Can you provide examples that NCQA will accept, besides the counseling center ex. used in the 2017 training?

NCQA's response:

Thank you for your question. Yes, public health agencies could meet the intent. Other examples of intervention agencies include - social service groups, food banks, women's shelters, etc.)

KM26

Some of the clinics in our state have been introduced to online resource guides that contain community resources for patients. These guides can be filtered by several resources types and by the county they reside in. If the resources provided on these lists meet the needs identified in KM21, can these be used? The online resource guides allow you to build personalized resource lists that can be printed and given to the patient. The section I am concerned about in KM26 states "include a date to demonstrate that the list is regularly updated or otherwise demonstrate how the list is maintained" If these lists are maintained by our State level offices and not the clinics themselves- will this be sufficient to meet the intent? Thank you for your time!

NCQA's response:

It's acceptable for practices to use an external source as a way of maintaining a list of community resources that meet the patients needs identified in KM 21. It's not clear to me by the description provided if the information is obtained online by the practice staff and then printed out or provided in another way to patients. Not all patients have access to the internet so if patients are to utilize this resource online, the practice should consider how it will provide the information to patients that don't have access to a computer or to the internet. Regarding your concern about the criterion requiring practices to demonstrate that the list is regularly updated and/or how it's maintained; the practice should be able to explain how they obtain the information and what process is followed or how they ensure the list stays current with their patient population needs? Is it reviewed on a routine basis and if it's determined that an additional resource is needed for patients that's not part of the online list, does the practice then obtain the information on their own in order to provide it to their patients? Again, it's acceptable to use this resource, these are just some questions you may want to consider if using an external list. This doesn't mean you need to have a written process in place but you should be able to demonstrate to the Evaluator during the virtual survey, how the practice monitors the list to ensure it provides the information meets the needs of the patient population and if not, what next steps are followed.

KM 27

Today while visiting a clinic we were talking about KM 27 they wondered what qualifies as a community referral? They also wondered if a referral to the infant toddler program qualified as a community referral?

NCQA's response:

Thank you for your question. Any referral to a community resource that is important to your patient population because it helps support their health and well-being would be appropriate. The infant toddler program may be appropriate to add to your list of community resources based on the needs of your patient population. Other topics may include smoking cessation programs, homeless shelters, food banks/pantries, parenting resources, weight management programs, immigrant resources, transportation resources, etc.. There are several criteria related to community resources that build upon each other. The practice will want to identify needed community resources in KM 21, maintain a current community resource list in KM 26 and then assess the usefulness of the community resources in KM 27. For KM 27, NCQA is not prescriptive about how practices review feedback from their patients/families/caregivers about community referrals. The intent of KM 27 is for the practice to assess the usefulness of the identified community resources (KM 26) to ensure that the practice has identified resources that benefit their patients, as their needs may change over time.

KM 28 - Case Conferences

If a practice has a policy/procedure in place and they invite outside community agencies and specialists to a case conference, but only the practice team and the patient/family/caregiver show up, does that still count as evidence?

NCQA's response:

No, KM 28 evaluates whether practices are holding case conferences regularly so this particular example where only practice staff and the patient/family/caregiver showed up would not be a good one to demonstrate the process. The practice should have use another example of case conferences that demonstrates all necessary parties present. The intent of KM 28 is for practices to go beyond the practice team and include external supports and facilities that can assist with and manage patient care for high risk patients seen by the practice. This involves having regular case conferences with all of the parties involved in the care, which could include families/caregivers but should also include any specialists or staff (such as nursing home staff) that help to manage the patient. Meetings between the primary care staff and patient's family in and of itself would not meet the intent of the requirement. To meet KM 28, the practice must demonstrate its documented process for holding case conferences regularly to discuss high risk patients' care as well as evidence of these case conferences. There is no minimum number of examples and NCQA is not prescriptive about how the case conferences are held, but it must demonstrate that this occurs regularly for high risk patients and that there is a time for all of the specialists and staff participating in the patient's care to meet and discuss. There is no minimum frequency, but they should be held regularly as appropriate to provide the needed care and support for the high-risk patient(s). Since this may be done with a variety of parties, NCQA is not prescriptive of what the evidence of implementation is, as long it demonstrate regular case conferences are being conducted. It may be in the form of case conference summaries or notes, but if there is another method that the practice wants to demonstrate case conferences are being

regularly held, that would also be accepted. Please also note that KM 28 is an elective criterion and may not be applicable to all practices, so if practices do not engage in these types of meetings regularly, it may select other elective criteria that may be more applicable to the patient population they serve.

Further explanation on KM28

Can you please explain the details of the regular "case conferences". Do these meetings have to be on specific patients? Would an EXAMPLE case study that is presented and discussed in a Medical Health Neighborhood meeting that has clinical and non-clinical partners included meet the intent of the criteria? Would case studies presented and discussed through Project Echo meet the intent of the criteria? Is there a frequency in which these "case conferences" need to occur?

NCQA's response:

Thank you for your inquiry. Yes, the case conferences should be patient specific. A case study presented and discussed would not meet the intent of the criteria. These case conferences are meant to be with other specialists and/or community support services being utilized by a patient for the purpose of discussing their care plan, including relevant treatment goals, patient preferences, barriers, etc. These meetings are to help all those providing care and/or support services for a patient to be aware of their specific needs and on the same page in regards who's responsible for which areas of the patient's health.

Patient Centered Access and Continuity

AC 01 & QI 04A

Can a survey which includes questions about access be used to meet the requirements for both AC 01 and QI 04A (as one of the three required dimensions)?

NCQA's response:

Thank you for your question. Yes, it is common for there to be overlap between these criteria. The intent of AC 01 is to assess the access needs and preferences of your patient population. To get to the information needed you may need to review how you're currently obtaining patient feedback on access needs. For example, a patient survey may ask patients if they're able to get an appointment when needed, however, that question doesn't tell you when patients want to access the practice. The practice may be offering access when the majority of patients don't or aren't able to utilize it. This criteria is more about how/when patients would like to access appointments. To meet this criterion the practice needs to provide a documented process and evidence of implementation. The documented process should indicate how the practice is collecting feedback from patients (such as through a survey) and how the practice assesses that information (such as at team meetings). Evidence of implementation may include but is not limited to providing your patient survey and an analysis of the results. We want to see that you are collecting and looking at the feedback from patients to see there's need to make adjustments to the access you're providing to patients. Here are some questions a practice may want to consider

for AC 01: 1) What data are you already collecting on patient access (e.g. surveys, use of appointments)? Is it current and does it cover the whole patient population? 2) How often do you need to assess the access needs of your patients? 3) What variables may impact changes in the use of appointment types? 4) If you're using patient satisfaction surveys, how many patients are actually responding? If the response rate is low you may want to consider another mode of collecting feedback in order to get more input. 5) Do the questions on your survey ask patients directly about their needs or preferences in regards to access? If you have any further questions please do not hesitate to reach out.

AC-02/AC-03 (and TC-05/TC-06)

I work with a very small clinic in a rural town. They are mostly a one woman show. Their provider is a Nurse Practitioner and she handles everything with the exception of some billing and taking phone calls, which is done by a part-time employee not located inside the clinic when the NP is working at her other job from Tuesday-Friday. This clinic is open on Sunday (10:00am to 4:00pm) and Monday (1:00pm to 7:00pm) for routine, urgent, and same-day appointments. They are interested in earning PCMH recognition through NCQA. With that background information, I have a few questions: 1) Can they earn NCQA recognition even though their clinic only has 12 hours of regularly scheduled operation hours each week? (She is on-call all the time and has given her cell phone number to all patients in her small community, and even makes house calls). I wondered about AC-02 (Core) requiring same-day appointments for routine and urgent care appointments. She doesn't have a schedule for patients to be seen Tues-Sat, but will see them if there is a need for same-day. This Criteria is asking the clinics to provide same-day appointments for routine AND urgent care. Would she still fulfill this requirement based on having same-day appointments available on Sunday and Monday? 2) If this clinic is only open Sunday from 10am-4pm and Monday from 1pm-7pm, will this fulfill the requirement in AC-03 (Core) to provide routine and urgent appointments outside regular business hours since she has appointments on Sundays and after 5pm on Mondays despite only having appointments on those days, not all week? 3)TC-05: Do you have a list of certified EMRs for this criteria? Is Office Ally acceptable? 4)TC-06: (Core) How can this clinic complete the patient care team meetings with one employee and receive credit for this core criteria?

NCQA's response:

Thank you for your questions! 1) Eligibility for PCMH is not based on the number of hours the practice is open but rather by the fact that the practice provides **principle, primary, whole-person care to at least 75% of the patients it sees**. For AC 02, the practice must show that it has same day appointments available for both routine and urgent care needs every day that the practice is open (Monday-Friday). Sunday would be considered extended hours, so it would not be necessary to demonstrate same day appointments for those days. NCQA is not prescriptive regarding how many appointments must be left open as same-day, but it should be based on patient need and demand to ensure prompt access to care. It's also up to the practice's discretion to triage patient needs appropriately. Separate slots for routine and urgent needs are not required, but rather some same day appointment that could be filled for either purpose. 2) Yes, for AC-03, the practice meets the intent by providing hours on Sunday and after hours on Monday (5-7pm). Offering after hours care is intended to expand access to patients based on their needs, so practices should consider whether the extended hours provided meet the needs of the patient population. 3) For TC-05, the practice must have an ONC Certified EHR; you can review the list of certified systems on the ONC website: <https://chpl.healthit.gov/#/search>. Based on the website, it appears 4 versions of Office Ally are certified, so you can review the detail there to identify whether

your practice's system is included. 4) If a practice only has one care team member (the clinician), it can demonstrate the process for preparing for patient visits for TC-06. The intent of the structure communication is for the practice to review the patient schedule and prepare for visits to ensure effective and efficient patient visits.

AC-02 and 03

I wondered about AC-02 (Core) requiring same-day appointments for routine and urgent care appointments. She doesn't have a schedule for patients to be seen Tues-Sat, but will see them if there is a need for same-day. This Criteria is asking the clinics to provide same-day appointments for routine AND urgent care. Would she still fulfill this requirement based on having same-day appointments available on Sunday and Monday? 2) If this clinic is only open Sunday from 10am-4pm and Monday from 1pm-7pm, will this fulfill the requirement in.

AC-03 (Core) to provide routine and urgent appointments outside regular business hours since she has appointments on Sundays and after 5pm on Mondays despite only having appointments on those days, not all week?

NCQA's response:

For AC 02, the practice must show that it has same day appointments available for both routine and urgent care needs every day that the practice is open (Monday-Friday). Sunday would be considered extended hours, so it would not be necessary to demonstrate same day appointments for those days. NCQA is not prescriptive regarding how many appointments must be left open as same-day, but it should be based on patient need and demand to ensure prompt access to care. It's also up to the practice's discretion to triage patient needs appropriately. Separate slots for routine and urgent needs are not required, but rather some same day appointment that could be filled for either purpose. 2)

AC-03, the practice meets the intent by providing hours on Sunday and after hours on Monday (5-7pm). Offering after hours care is intended to expand access to patients based on their needs, so practices should consider whether the extended hours provided meet the needs of the patient population.

AC 03 - Routine Visits in Urgent Care Center Outside Business Hours (02/26/2018)

For AC03, if a practice uses an urgent care clinic within the same system to provide appointments outside of regular business hours, what types of routine appointments must be included? For example, the practice prefers not to have annual physicals/wellness visits scheduled with urgent care, but will let patients schedule for blood pressure checks, routine med refills (not pain medications), and non-urgent acute concerns (e.g. sore knee, rash, etc.).

NCQA's response:

Patients should be able to schedule ANY routine or urgent care need outside of business hours with the urgent care. The intent of this criteria is to enable patients who cannot seek care during traditional business hours due to other obligations to fulfill all their PCP needs.

AC 03

Is it OK if the services are provided by the urgent care on a walk in basis (no appointment needed)?

NCQA's response:

Practices can use urgent care facilities to provide appointment outside business hours, but those appointments must be scheduled, and must accommodate both routine and urgent needs to fully meet the intent of AC 03.

AC-03 and what counts as outside typical business hours

I understand that in AC-03 under the 2017 standards it is looking for clinics to be open outside typical business hours (8:00 am-5:00 pm) on certain days. If a clinic chooses to be open one day a month or a week from 10:00 am-7:00 pm will that work since they are open the additional two hours past 5:00 pm? Or would they still need to be open from 8:00 am to 7:00 am for the criteria to be met?

NCQA's response:

For AC03 hours can be any length of time outside the practice's regular business hours that meets the patients needs. It could be one day a month or staying open until 7 if your practice has determined that best meets the patient needs then it would be acceptable. Keep it mind it does not have to be for every provider. You may want to obtain additional feedback from your patient population to determine which days the practice could provide extended hours that would best meet patient needs. Extended hours should provide the same care services, both routine and urgent scheduled appointments during this time. The intent of this factor is to provide additional access to your patient population, so it is required that you make your patients aware of these extended hours.

AC03

I submitted a question previously regarding AC03. I work with several small practices with solo practitioners. Has NCQA provided or considered providing any exceptions to the rule for AC-03 for clinics with only one practitioner?

NCQA's Response:

Small practices with limited staffing, such as a solo provider, can use urgent care facilities, telehealth or another practice that has access to the practice's EHR to provide appointments outside business hours. These appointments must be scheduled, and must accommodate both routine and urgent needs to fully meet the intent of AC 03. Any telehealth appointment would need to provide the same level of service as an in-person appointment.

AC-03

I work with a Pediatric Clinic. They are open from 8-8 M-F 9-5 Sat and 1-5 on Sunday. The appointments after 5 and on the weekends are reserved for patients that are sick and come in rather than going to an urgent care or the ED. They clinic rarely schedules Well Child Checks or physicals after 5. Does the clinic need to offer WCC or physicals available after 5 or on the weekends to fulfill this criteria?

NCQA's response:

Extended hours should provide the same care services, both routine and urgent scheduled appointments during this time. Only offering urgent care appointments does not meet the intent of this factor. The intent of this factor is to provide additional access to your patient population. You may want to obtain additional feedback from your patient population to determine which days the practice could provide extended hours that would best meet patient needs, as in AC 01.

Question:

Our clinic has two locations. They use the same EHR and it is the same providers, but they rotate locations. The clinic's are 16 miles apart. One clinic is open 8-8 M-F, Saturday 9-5 and Sunday 1-5. Our second location is open 8-5 M-F. Does having the extended hours in our other clinic fulfill AC-03 for our second clinic that doesn't have the extended hours?

NCQA's response:

Yes, if the patients seen at both practice site locations are able to schedule routine and urgent care appointments during extended hours and the patient medical record information is available at the site that is open, this would meet the intent of the criterion. The organization's documented process should outline this information and the sites must demonstrate how they provide this information to patients (e.g., via brochure, website, other advertisement of the availability for scheduled appointments during extended hours).

CC-03 and CC-05

How would you suggest a clinic show they use clinical protocols or decision support to determine if a patient needs labs or images or if they need to be seen by a specialist? (As required in CC-03 and CC-05) Thank you!

NCQA's response:

Thank you for your question. For CC 03 and CC 05, you will need to provide evidence of implementation. I would say that the best way to do it is to show it through your EHR. Perhaps you have a function in your system that shows a test is duplicative or unnecessary. You can either show this on a screenshot and provide an explanation on how the screenshot meets the intent of the component. I would say that best way is to present it virtually during your check in. I think it is easier to do it this way because, in some cases, explaining a screenshot can be limited whereas explaining it live and showing your system would be more beneficial. Hope this helps.

AC04 - documented process

Clinic has created a "how to" document for nurses who will be performing a triage symptom assessment over the phone. It provides step-by-step instruction, as well as screen shots with arrows showing where to click next, on navigating through a particular electronic system (possibly a feature connected to the facility's EMR). >> My interpretation of Documented Process on page 16 of the NCQA PCMH Policies and Procedures (2017 edition, version 1) tells me that - although this document provides instruction on "how to" work through a symptom assessment - it does not provide the overall documented process NCQA is looking for in AC04 (providing timely clinical advice by phone). >> Can you provide some clarification on the documented process AC04 is seeking? Am I over thinking? Would this document satisfy the documented process requirement for AC04?

NCQA's response:

Thank you for your question. The intent of this criteria is for practices to monitor response times against its defined standard outlined in the documented process for calls received from patients seeking clinical advice when the office is open and when its closed. While a "how to" respond section is helpful, the documented process must feature standards for who in the practice will respond and when. If the defined standard for responding to calls is different for during and after hours then the practice is expected to monitor its response time against both standards and provide a report that displays both results.

AC-04

For AC-04 providing timely clinical advice. Can a clinic provide a 7 day log of their phone calls as a report. Their EHR doesn't have the capacity to track telephone encounters. This log would track during normal office hours as well as after business hours.

NCQA's response:

What you have described would meet the intent of AC 04 as long as it captures all clinical advice calls placed to the practice both during and after office hours and denotes whether the response from the practice fell within the time frame established by the practice.

AC-04

I work with a couple large Pediatric Clinics. During office hours nurses take clinical calls and return those calls. For the report for AC-04, the 7 day log does it need to be all the nurses or could it be nurse A and B for M-W and nurse C and D for Th-Sat? Also does it have to be all calls or only calls where clinical advice is given? The doctors keep an after hours log to satisfies the after hours portion.

NCQA's response:

It must be all calls in which clinical advice is given. All calls involving clinical advice must be recorded, so all nurses/clinicians answering those calls must be in the log.

AC06- Group Visits

In 2014 PCMH Standards, NCQA accepted a scheduled clinical group visit where clinical care is provided as an "alternative appointment". I do not see this information listed under AC06 anymore. Do clinical group visits count towards AC06 in the 2017 Standards?

NCQA's response:

The intent and expectation for AC 06 differs from the alternative clinical encounters factor in PCMH 2014 where we had accepted group visits and nursing home visits. For AC 06, the focus is on appointments by telephone or other technology-supported mechanisms. This is an appointment that is in lieu of an in-person office appointment using technology. A visit where a clinician sees more than one family member during an in-person office visit or a nursing home visit would not meet the intent of this criteria.

AC-09

Can I get some clarification on AC-09. I don't really get what NCQA is looking for. Also where are the clinics getting the information about Health Disparities? Is it from information they have collected or from a community needs assessment?

NCQA response:

The intent of AC 09 is for the practice to conduct an assessment for the purpose of identifying differences in access experienced by a specific vulnerable population. The practice should (1) identify a vulnerable patient group through data collected within the patient medical record or community data, and then (2) review reports that monitor access to stratify and identify any disparities. While data from a community needs assessment could be used, please note that state or national data is too broad - the data obtained should be specific to the patient population to ensure that any actions taken based on the data is applicable and will assist with tailoring access needs for the patients at the practice site. If your organization is expansive, it may be that data covering all sites is also too broad. AC 09 is looking for the practice to consider health disparities and assess whether one or more of these disparities has an effect on a vulnerable group of patients being able to access services. Access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. Equity of access to primary care services requires interventions to take into account social determinants of health, the needs of patients and populations, as well as the resources available to them. Evidence could be demonstrated if a practice identifies a vulnerable group, such as its homeless patient population, and then uses reports on access that it already monitors to stratify by that patient population and identify any possible health disparities in access; one example of this might be if the practice stratifies its report of no shows and sees that its homeless patient population has a higher no-show rate than other patient groups.

AC 10

I work with a large pediatric clinic. They have over 17,000 active patients. They are implementing AC-10 empanelment to their practice. Their policy is progressive in the sense that they update the PCP when a patient comes in for their annual exam. Not every patient comes in for an annual exam. They figure over a three year period they will have captured all the active patients and empaneled them to their PCP. Does the progressiveness of this policy work for does complete empanelment have to occur prior to submission?

NCQA's response:

For AC 10, as long as the practice can provide the process that staff follow to work with patients to help them determine or change their preferred personal clinician, it could meet the intent. The method of identifying this personal clinician is up to the practice, but there must be a way for patients to have a say in who their personal clinician is and discuss changing providers if needed to ensure patient-centered care.

AC 11

For AC-11 If the clinic set the goal and doesn't make it they don't get penalized right? It just that the clinic is working toward the goal. Also can they pull the report similarly to the 2014 standards by taking a at least 5 days work and look at all the patients who were seen by their PCP vs patients not seen by their PCP?

NCQA's response:

For AC 11, there is no minimum percentage or penalty for not meet the goal that the practice sets for continuity. The intent of this requirement is that practices are monitoring continuity and can use the data collected to assess processes that might improve continuity so patients can more often see their personal clinician or care team. The reporting methods are up to the practice but whatever report is provided should demonstrate the assessment for how often all clinicians are seeing their empaneled patients. The report should include the percentage of visits that occur with the patient's personal clinician or care team.

AC11

First sentence refers to a PCP and "care team." Please define care team. 2017 S&G appendix 2 glossary defines a 'practice team,' but not a 'care team.'

NCQA's response:

For AC11 if the mid-level practitioner (APRN or PAs) has their own panel of patients, they would be evaluated separately when monitoring patient visits with selected clinician or care team. If the practitioner shares a panel of patients with a primary care clinician, then they would be counted as part of the clinician's care team. Any clinician or clinician team at the practice that has their own panel of patients should be included in the analysis. The intent of AC11 is for the practice to monitor the continuity of the patient seeing their selected clinician or team. The frequency may be different each provider which is ok. The purpose of the practice looking a this type of report is to see if patients are able to see their selected PCP and where there might be imbalances among the providers which could be

addressed. The practice should set goals such as by percentage, number of visits, etc. for the frequency patients should be seeing their selected provider.

AC13

Please define "actively manages." Although reports are run, reviews are made, and suggestions are offered, each of our providers/clinicians ultimately manages his/her own panel size. The practice itself does not mandate the clinician's panel size. Can you give examples of what would qualify as "actively managing?"

NCQA's response:

What you have described would meet the intent of the criteria.

AC 13

AC-13 Does NCQA look at all the patients empaneled across the practice or do they look at a subset, like chronic patients. Also do the panels need to be even? Some providers have a high carrying capacity than others.

NCQA's response:

For AC 13, the practice should have a process to look at each provider's entire panel size, compare to an ideal panel size (likely through some calculation) and then have a process to address any imbalances. This requirement is meant to look at all patients, not just ones with certain conditions, though that information may be used in the analysis of panel sizes (e.g., if a provider has a smaller panel size than the calculation suggests but many of those patients are more complex, then the practice could determine that their particular panel size is appropriate). Please note this item is an elective criterion, so it's not required to meet PCMH requirements. If this is not pertinent to practices, other electives can be pursued to achieve the 25 required elective credits.

AC 14

Can I get some additional clarification on AC-14. What is NCQA looking for? What are some examples of what other clinics have done? Idaho Medicaid doesn't pull data/reports per clinician. It only pulls per clinic would this work or does it have to be per clinician.

NCQA response:

The intent of AC14 is to review what patients health plans, ACO, or outside entities attribute to the clinicians, so the reports must be by clinician. A practice would review reports, investigate unknown patients and communicate with payers to reconcile lists. A practice could include primary payers/ACO. The practice does not need to reconcile with all external entities but should focus on their primary ones. Evidence of implementation would show feedback on review to payers. The documented process provided should include details for your staff to follow in regard to how the report should/is used.

Care Management and Support (CM)

CM-01

For the evidence of CM-01 what are you looking for as for as protocol for identifying patients. For A. patients who have a positive PHQ-9 or for C. patients what are diagnosed with diabetes and an A1C over 10 satisfy the evidence of CM-01?

NCQA response:

Yes, both of those plus a protocol from another category would meet the intent of CM 01.

CM-01 and Appendix 3

In Appendix 3 about the record review workbook it says under step 3"1. *The intent of the criterion is that the practice uses defined guidelines to identify true vulnerability—a single indicator, such as cost, may not be an appropriate indicator of need for care management.*" If a clinic has select diabetes, asthma, and depression, as their protocol for Care Management and a patient only has one of these condition, then they patient might not qualify for CM? Does that patient have to have multiple conditions to qualify? What does it mean by single indicator?

NCQA response:

What this appendix is trying to convey is that meeting a single indicator in and of itself does not necessarily mean a patient needs care management. For instance, if the practice has chosen diabetes as a criteria for care management, not every diabetic patient needs to be actively enrolled in care management. Those with a strong understanding of their disease and a history of treating it well may not be a suitable care management candidate. It is up to the discretion of the clinician to decide at that point. Those who do meet multiple criteria for care management would most likely be strong candidates for care management.

CM-02

Does that mean that 30 patients need to be receiving some form of care management or is it that 30 patients meet the criteria outlined in CM-01? For example if a clinic's patient population is 3,500. Wouldn't saying 35/3500 patients qualify as outlined in CM-01 for care management satisfy that report?

NCQA response:

CM 02 is asking how many patients are actively enrolled in and receiving care management. It is not necessary that all patients that meet the criteria set forth in CM 01 go into care management, it is the clinician's discretion. However, at least 30 people must be enrolled.

CM-03

For CM-03 it says "applies a comprehensive risk stratification process for the ENTIRE patient panel" Does Entire refer to the patient's entire patient population or the entire care management population created in CM-01?

NCQA response:

CM 03 applies to the entire patient population, and would be done in place of CM 01. If CM 03 is met CM 01 is given automatic credit.

Question:

What does NCQA mean when it says Risk Stratification? Does that refer to something the patients fill out or does it refer to criteria or guidelines that the clinic has set.

NCQA response:

A risk stratification tool is used to categorize patients within the practice by a risk score. Some states and other entities have developed guidance and tools for risk stratification, like AAFP and HCC. If the practice would like to conduct their own risk assessment, it could use data from other elective criteria that ask the practice to look at stratifying the population by social determinants (KM 07) for interventions, demographic characteristics (KM 08) for educational materials, population health management (KM 11) for disparities in care, equity of access (AC 09), assessment of health disparities (QI 05), and experiences of vulnerable patient groups (QI 07). CM 03 might identify some in those subpopulations that would benefit from care management.

The following links may be helpful Risk stratification rubric available to members of the AAFP - <https://nf.aafp.org/Shop/practice-transformation/risk-stratified-care-mgmt-rubric> Risk stratification rubric from California Quality Collaborative - http://www.calquality.org/storage/documents/cqc_complexcaremanagement_toolkit_final.pdf

CM-09

Our care coordinator creates care plans with the patients on paper. The care plan is then scanned into the patient's chart and is located under the Care Coordination tab of the patient's documents. When the care plan is updated the updated version is scanned into the patient's chart. All staff members who enact with the patient has access to the scanned care plan. If an outside organization who is also working with the patient request a copy the care plan is faxed to that organization. Does that fulfill the intent of the CM-09?

NCQA's response:

CM 09, the practice must demonstrate its capability to make their patient's care plans available securely to other care settings, such as hospitals, specialists, or other care facilities that could be managing patient care. The way in which this care plan is shared may vary and NCQA is not prescriptive, but examples include sharing care plans via shared medical records, HIEs or other shared systems that enable staff from different care settings to view the patient's care plan for continuity and optimal care coordination while the patient receives care from multiple settings. Scenarios in which these systems may be shared could include if a practice is part of an integrated health systems, ACO, Clinically Integrated Network or another arrangements that enable sharing of the patient's care plan across settings. Please note that this requirement is elective and is not required for recognition if this capability is not available for the practice. If the practice does have a capability like this, it must provide its documented process that outlines how these care plans are made available across settings as well as demonstrate evidence of this information sharing during the virtual check-in with an evaluator.

Care Coordination and Care Transitions (CC)

CC-03

I can get some examples of Pediatric Specific labs or imaging that would fulfill CC-03. Would it fulfill the criteria to have our mid-levels get a physician approval before they order an MRI?

NCQA's response:

No. a physician approval alone would not meet the requirement. The intent of elective criterion CC 03 is for practices to have processes in place for both lab and imaging tests, based on evidence-based guidelines, to ensure judicious and appropriate resource use. NCQA is not prescriptive regarding the number of protocols that are in place, but the practice must demonstrate that it follows evidence-based protocols to help guide the decision-making process when determining whether or not to order both lab and imaging tests for patients. So, in regard to your example above, NCQA would be looking for the evidence-based protocols guiding the physician that helps he/she to make a determination about the necessity of the test. An example of this could be following a clinical protocol established for the appropriateness of PSA screening based on current guidelines - this could include protocols for the ordering clinician to consider age and circumstances of the patient that would lead to ordering or not ordering a screening test. Similarly, for imaging tests, this could be a protocol in place to determine whether or not it is appropriate to order imaging for a patient presenting with low back pain. The practice would need to demonstrate evidence of its protocols during the virtual check-in to meet the elective criterion.

CC-03 continued...

I am following up after my question was answered (Case 00163732). I have two additional questions. 1. To fulfill this criteria does a clinic have to have protocol for both Lab and imaging? Or is it one or the other. 2. In my original questions I asked for some pediatric specific examples. I don't feel like PSA screening or low back pain are really pediatric specific. Are there other more Ped specific examples NCQA has seen other clinics use?

NCQA's response:

1. Yes, the practice must demonstrate that it has clinical protocols in place for both lab and imaging tests to receive credit on CC 03 and achieve the two elective credits. 2. Some pediatric specific examples can be found in the list of the American Academy of Pediatrics' Choosing Wisely Recommendations: <http://www.choosingwisely.org/societies/american-academy-of-pediatrics/>. Any clinical protocols that are followed to determine whether or not a specific lab or imaging test are necessary would meet the intent. If these protocols are not in place, the practice could still achieve recognition by selecting other elective criteria on which to report.

CC-03 and CC-05

How would you suggest a clinic show they use clinical protocols or decision support to determine if a patient needs labs or images or if they need to be seen by a specialist? (As required in CC-03 and CC-05)

NCQA's response:

For CC 03 and CC 05, you will need to provide evidence of implementation. I would say that the best way to do it is to show it through your EHR. Perhaps you have a function in your system that shows a test is duplicative or unnecessary. You can either show this on a screenshot and provide an explanation on how the screenshot meets the intent of the component. I would say that best way is to present it virtually during your check in. I think it is easier to do it this way because, in some cases, explaining a screenshot can be limited whereas explaining it live and showing your system would be more beneficial.

CC-04 Referral Tracking

I am hoping to get some clarification on CC-04. When says track referrals to specialist does that mean every referral that go out of the clinic or is just to specialty clinics like the urologist or the cardiologist? Does this also include Behavioral Health referral?

NCQA's response:

For CC 04, practices do not need to track all referrals but are expected to track important referrals, and the practice's definition of what it considers to be important referrals should be clarified in the practice's documented process to ensure all staff are aware of what referrals need to be managed. Please note this core criterion requires that practices show their process and evidence of the process to provide pertinent information to the consultant or specialist as well as tracking referrals to completion, including flagging and following up on any overdue referral reports.

CC-05

How does a clinic prove they use clinical protocols or decision support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician? How is this tracked?

NCQA's response:

To meet elective criterion CC 05, the practice must demonstrate the decision-making process used to determine the appropriateness and need of referrals. This could include protocols or processes that the practice uses within its systems or on paper that guide the staff with determining whether or not a patient need can be handled in the office or whether it needs to be managed by a specialist. This could be demonstrated during a virtual check-in where the practice walks the evaluator through the process used to make these determinations prior to a referral. NCQA is not prescriptive regarding how this is demonstrated, but the practice must show evidence of this decision-making process to achieve the 2 elective credits for the criterion.

Question:

CC-05 Does our practice need to have specific criteria/protocol of when to send a patient to a specialist for EVERY specialist? Or only certain ones or ones we use most often?

NCQA's response:

For CC 05 it is not necessary to have protocols for every possible specialist/diagnosis. It is up to the practice to determine which specialists or diagnoses are most relevant to them. The practice must demonstrate the decision-making process used to determine the appropriateness and need of referrals. This could include protocols or processes that the practice uses within its systems or on paper that guide the staff with determining whether or not a patient need can be handled in the office or whether it needs to be managed by a specialist.

CC06

This 1 credit elective can be obtained by providing Evidence of Implementation of "monitoring patient referrals" specifically to gather information about the specialists. Exactly what information [about the specialist] are we looking for here? Page 17 of the PCMH Standards & Guidelines (2017 ed, Ver 1) gives us a list of different types of evidence that could be used to provide the Evidence of Implementation, but we are looking for SPECIFIC examples (or your recommendations) of the evidence NCQA would like to see for this criterion. Is there an example of a spreadsheet or an example of a report that you can share? Are you able to share scrubbed examples of what other facilities have done to "monitor patient referrals" in an effort to gather information about specialists? Can you give us examples of the "guidelines or protocols" that might be adopted after retrieving & analyzing the gathered information?

NCQA's response:

For CC 06, the practice must demonstrate how it monitors outgoing patient referrals and identifies specialists or specialties that it uses most frequently. The evidence of this could be any method that the practice uses to track and monitor outgoing referrals. For example, if the practice has a log that they use to track outgoing referrals, it could be as simple as reviewing the log to monitor or tally how many referrals are made to different specialists and specialties. Evidence of this requirement could also include a report (if the practice's system has the capability) of the number of referrals by specialty or specialist. Ultimately, it's up to the practice to determine how best to monitor this information so that it is in a usable form for the practice to review the information and determine what (if any) actions it should take with the information collected. The intent of this requirement is for the practice to monitor where it is sending patients to (1) better understand the needs of its patient population so that it can tailor resources and other patient information accordingly, and (2) identify specialists with whom it may want to develop a relationship or establish expectations (CC 08 & CC 09). The PCMH 2017 evidence requirements were intended to be written in a flexible way to allow practices to demonstrate what they are doing to meet the requirement with a focus on meeting the intent of the requirement and allowing the practice to focus on the value-add work that helps them to achieve the goals of the program to systematically deliver patient-centered care.

CC-06

I work with a clinic that has their top referrals they send printed on pieces of papers that they give to the patients after the referral is sent electronically. These papers are divided by specialty. If there is a new specialty they will add them to the list. They keep track of frequency by how often they have to print new sheets. Does this satisfy CC-06. What are other ways to satisfy this criteria?

NCQA response:

The intent of CC 06 is for the practice to monitor its referral patterns and identify areas where it might improve care coordination (e.g., identifying clinicians most commonly referred to and ensuring that communication expectations are established for the relationship with those providers, like for CC 08). Compiling a list of commonly used specialists and monitoring how often it is updated and reviewed could meet the intent of this criterion. Evidence of implementation could also include a report pulled from their EHR, but it is up to the practice to determine the best way to track and demonstrate this information so that it is useful and helpful in achieving these care coordination goals. The practice can demonstrate that it monitors its outgoing referrals in a way that adds value to the practice and enables the practice to observe patterns and ensure coordination with those providers is optimal for patient-centered care.

CC-07 and 11

CC-07 and CC-11 Can I get some clarification on these two criterion. What method are you looking for clinics to gather "available information" about clinics and specialist to whom they are referring? Looking on Google review? Looking at their website? Talked to the practice? Or gathering feedback from patient who are referred there?

NCQA's response:

For CC 07 , examples of performance data could include reviewing patient survey feedback on their experiences with the specialist, CMS performance data, state report cards, HealthGrades (or other online review system that reviews specialist performance) and physician directories to assess performance; however, these are not the only methods a practice can use to evaluate quality of specialist care. Practices may also establish their own criteria to evaluate specialists. Examples could include evaluating the time it takes to schedule patients for specialist appointments (evaluating access), the sending of consult notes in a timely manner (evaluating care coordination), or the assessment of patient feedback about the specialist (evaluating patient satisfaction).

CC-11

What kind of report is accepted for CC-11? Can it be a clinic's report of all the outstanding referrals at the end of the month?

NCQA's response:

A report showing only the outstanding referrals at the end of the month would not fully meet the intent of this criteria. The report should provide the evidence of tracking the timeliness of referral responses and quality, which could be a log or other report that the practice can use to evaluate its process and follow-up with clinicians who may not be meeting the defined process standards to ensure effective and efficient communication about patient referrals. CC 11 also requires a documented process that outlines the process that staff follow to conduct this monitoring as well as a report that demonstrates the results of the monitoring. The intent of elective criterion CC 11 is for the practice to ensure that it is monitoring the receipt of information from specialists to whom they refer to ensure that the reports are timely (based on expectations communicated to the specialist) and that the reports have quality, complete information that can enable effective care coordination. It goes one step further than CC 04 by requiring practices to monitor the timeliness and

quality of the referral response. CC 04 does not require any monitoring of the specialists response, only that they track, flag and follow-up on overdue reports.

CC-12

When our practice and specialist are co-managing a patient do we need to update the specialist every time that patient is seen in our office or only when they are seen in our office for something related what the specialist specializes in? Example co-managing a patient who has hearing issues, do we need to inform their audiologist or ENT every even if they are seen for the Flu or a broken leg?

NCQA's response:

How often a practice communicates with a specialist for a patient they are co-managing should be agreed upon by both parties. NCQA is not prescriptive regarding the frequency the practice updates a specialist on the care of a patient being co-managed. Typically a practice would only share care information/changes for a co-managed patient that's relevant to the condition for which the patient is being co-managed for. However, there may be instances when a specialist wants to know all details about a patient's care. These details should be decided upon as part of the agreement between the two clinicians.

CC 13

Do our providers need to ask about every medication that is prescribed or can we choose to focus on medications related to specific diagnosis, like diabetes or AHDH?

NCQA's response:

No, practices are not expected to provide cost implication information for all medications. However, it is expected that the practice provide all patients affected by the same drug or treatment plan with the same information/materials about the cost implications. Please note, this criterion requires the practice to have a documented process and evidence of implementation reflecting what's outlined in its process.

CC14, CC15, CC16

1) Is it required that the PCP actually receives alerts that the patient has visited hospital or ED? ... or does having the capability to access the information fulfill this competency? 2) Is there a % of patient population that must be met on each of these Cores?

NCQA's response:

The intent of CC 14 is for the practice to have a process in place to proactively identify patients who have been admitted to the hospital or ED to ensure prompt care coordination and communication with the facility. The practice could have a process where it receives active alerts from hospitals or EDs with which it has a relationship; however, it would also meet the intent if the practice has access to a hospital and ED's systems for the practice to have a process in place where it systematically checks to see if its patients have been admitted. Regardless of method, this process must be done on a regular basis to identify patients admitted as soon as possible and ensure communication with the facility can occur for optimal care coordination. For this criterion, the practice must provide its documented process that outlines how it identifies patients proactively and a report or log of patients admitted to the hospitals or ED. Once a practice is aware of an admission or ED visit, CC 15 asks the practice to demonstrate its process for sending

pertinent patient information to the facility that will assist in the care provided there. For this criterion, the practice must provide its documented process and demonstrate how it shares information with the hospital or ED. Then, in CC 16, practices must provide their process and demonstrate how they follow-up with patients to ensure that any follow-up care or referrals that may be needed are identified and scheduled promptly. There are no percentage requirements for these criteria.

CC 14 - Report Questions (03/20/2018)

If a practice does not have a way to generate a report from their EHR on unplanned hospital or ED visits, is it acceptable for them to make a report based on a sample of their patient population? E.g. list each patient who the practice identifies as having a qualifying admission/visit over a three month time period? ~If a practice is part of a health system which is the only hospital and ED in a rural community, do they have to have a documented process/notification exchange mechanism with the nearest hospital outside their system (over an hour drive away)?

NCQA's response:

While CC 14 does require a report, this is one criterion where we're not looking for the numerator/denominator. What we want to see is that your practice is receiving regular reports and/or communication in a timely manner regarding who has been admitted to the hospital or visited the ED. This report could be a listing/log of patients seen over the course of a week, month, etc. We would like to see demonstration that you're collecting this information on both hospital admissions and ED visits but there isn't a specific proportion required. If you are in an area with only one hospital, it is not necessary to document exchange with hospitals outside your community.

CC-14

A different clinic I work with is in more of an urban area which has 3 hospitals. They are able to get reports from 2 of the hospitals but the third isn't very helpful with sending admission or ED visit notifications. Is it OK if their report is made from the 2 hospitals which send them notifications?

NCQA's response: Yes.

CC 15

Can you please clarify for CC 15 if the reference to "three examples" means three instances of exchange of information when a pt is referred to ED or hospital or three methods of communication like phone, fax, and email?

NCQA's response:

For CC 15, the reference to providing three examples of exchange of patient clinical information between the primary care practice and admitting hospitals and emergency departments refers to three instances of the exchange, not three methods. NCQA is not prescriptive regarding how the practice communicates with these facilities, and the practice should outline their methods and process for communication in the documented process provided.

CC-15

I am hoping to get some additional clarification on CC-15 because it is really up to the hospitals if they communicate with the clinics. Clinics can't force them to request information from them. What are the expectations from the clinics on the criteria?

NCQA's response:

NCQA does not expect that the practice will always be notified when a patient has been admitted to a hospital or ED; however the expectation of core criterion CC 15 is that when the practice is made aware that a patient has been admitted, it has a process to send clinical information that may be pertinent for the patient's care to the hospital or ED. The intent of this requirement is to ensure that information is shared as soon as possible after the practice is made aware of an admission to ensure that care is coordinated, information is shared, and patient needs do not fall through the cracks. For CC 15, the practice must provide its documented process for sharing clinical information and demonstrate how it follows this process once aware of an admission. Please note the requirement for demonstration of two-way exchange with a hospital during patient admission, CC 18, is an elective criterion and not required for recognition.

CC-17

I work with a clinic that is owned by the local hospital. They share the same EMR, therefore the hospital has access to clinic notes in the event that a patient from the clinic doesn't the ER or is admitted to the hospital. The same is true for the clinic when a patient is in the hospital the clinic has immediate access to the notes from the hospital. For CC-17 would a letter explaining clinic hospital relationship satisfy the documented process required?

NCQA response:

For elective criterion CC 17, practices must provide their documented process to share patient information after hours as well as evidence. If the practice has a shared EHR with acute care facilities (i.e. urgent care centers, EDs, hospitals), the documented process and evidence could reflect the process used to share information after hours within that shared system, but the practice would still need to show how the information is accessed. Please note, however, that in the case that a patient is at an acute care setting outside the system, the documented process must also highlight how the information can be shared with facilities external to the practice site that do not share an EHR. It is required that the process be established for sharing information with any acute care setting after hours, not just those that share systems.

CC-21

Idaho has an Immunization Reminder Information System (IRIS). Clinics are required to input vaccines under the age of 18 are preformed what their clinic. It also allows other clinics around the state can see what Imms their patients they are seeing have received in Idaho. Some EHRs link to this system automatically, while others require clinic staff members to enter the data manually. If a clinic has to add the data manually does it still satisfy CC-21 B because the information is the same, but it just takes the nurses a little extra work to do it manually because IRIS and the EHR aren't currently compatible?

NCQA's Response:

A practice that enters its data manually into an immunization registry can still get credit for CC 21. Regardless of how the practice is providing the data, the important thing for this requirement is that the practice is providing the data for others to utilize. Please note, it's also important for the practice to use the applicable data found in the immunization registry provided by other facilities

Performance and Quality Improvement (QI)

QI01

I work with a practice who is trying to fulfill the requirements for QI01. Unfortunately, they utilize an EMR that was originally set up as a shared EMR with the community. They are unable to filter reports on patients that pertain to just their practice for quality measures. The reports compile other community providers and patients that are not their own. I know NCQA allows a manual chart audit similar to the RRWB in instances that reports cannot be generated. Can you tell me what the parameters would be regarding QI01. Would the practice need to audit 30 patients that are different from the ones in CM section, would they need to audit a separate 30 patients for each category within QI. I would assume yes, but I just want to clarify so I can advise this clinic appropriately.

NCQA's response:

Yes you can use a manual chart audit following the same parameters as the RRWB. At minimum, you would need to sample 30 patients, but more increases the reliability of the sample. You would not use the same patients as the 30 patients you have identified for CM 04-CM 08. Instead you would look at the patients who fall into the QI measure denominator. Using a systematic randomized approach or by visit date (similar to the RRWB).

QI-01

In order to satisfy the immunization measure in QI-01, can a clinic who does not administer vaccines (because of their smaller size and because they are still working on getting the fridge, etc.) receive credit for this criteria by measuring that they addressed the need for a particular immunization to a patient in a qualifying age group? They would use the number of patients seen in that age group who needs a particular immunization (i.e. Pneumovax) as the denominator and the number of patients the provider addressed the referral to get the Pneumovax at the local health department as the numerator. Or, in order to complete the criteria requirement, would they need to track to make sure the patients they recommended receive the Pneumovax got the vaccine (at the outside organization).

NCQA's response:

To meet QI 01A the practice should use the number of patients eligible for the immunization as the denominator and the patients who have received the immunization (even from an outside organization) as the numerator.

QI-01 D and QI-02 A

Can you provide some examples of metrics that fulfill QI 01 D and QI 02 A? I reviewed your crosswalk and was surprised to see that you had assigned ADHD F/U as category QI 02 A whereas I would have said this was a QO 01 D (BH) measure. Likewise, I noted that depression screening is a preventive measure (QI 01 B) whereas I would have counted it as a QI 01 D (BH) measure. I am interested in all measures that might suffice but I am especially interested in 1) pediatric measures 2) measures that can easily be calculated by small practices. In general measures such as hospital rates for ambulatory sensitive conditions are beyond the scope of most small practices. Thank you for your assistance.

NCQA's response:

Depression screening would be accepted as either a preventive care measure OR a behavioral health measure. Practices may not use the same measure to meet more than one measure category so they may use their depression screening measure for a preventive care measure OR a behavioral health measure. Similarly, the ADHD F/U measure may be used as either a care coordination measure or a behavioral health measure, but may not count toward both criteria in PCMH. Measures may be developed by the practice or specifications may be used from other sources, such as USPSTF, CMS, CDC, NCQA etc. I took a look at NQF and they have two BH measures for the pediatric population (<http://www.qualityforum.org/ProjectMeasures.aspx?projectID=74022>): Pediatric Symptom Checklist (PSC) and Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment. For QI 02A, some examples include providing a summary of care record to another provider for referrals, communication during care transitions, reconciling medication after a care transition, receiving a report from a provider to whom the patient was referred, and following up on labs or imaging as care coordination measures. However, we understand that these are not as common for pediatric sites. Some examples for pediatric practices might include reporting to immunization registries, following up on pediatric visits to after-hours care, or evaluating the use of community resources or education programs to which the practice referred parents/children by following up with either the resources or the parent. For these measures, we are looking for evaluation of the communication/coordination that occurs between providers OR providers and patients.

QI Core 02

I have a question regarding QI 02 (Core). In the 2014 Standards this measure specified "Data provided by an external source (such as a health plan) represent 75 percent of the practice's eligible population." I do not see the same language in within the description for QI 02. Are practices still required to use data that represents 75% of the practice's eligible population"? Also, on QI-02, would clinics need data that reflects their whole patient population, not just their Medicaid population for example?

NCQA's response:

Yes, the expectation would be that the data would still represent a majority (>75%) of your patients, if using data from an external source. For QI 02, practices should provide measures that include data across the practice's patient population. This

means the data should include the majority of the practice's patient population (at least 75%). If a practice's population is mainly Medicaid patients (at least 75%), then providing only data from that patient group within the practice would be acceptable.

QI-02

I can get some clarification or examples of what measures affect Healthcare cost. Would reducing patient's visits to ED count? What else? Thank you

NCQA's response:

Thanks for your question. The intent of QI 02B is for practices to use measures to help them understand how efficiently they're providing care and judiciously using resources. Examples of acceptable measures includes medical cost per medical visit, # of medications prescribed, use of high cost medications, use of imaging for low back pain, redundant imaging or lab tests, emergency department utilization, hospital readmission rates, use of generic vs. brand name medication, # of patients who went to urgent care during open office hours, # of referrals/ED visits for needs that could be addressed in the office. Please note that this is not an exhaustive list, just some accepted health care costs measures. If you have additional questions, please let us know.

QI-02 B

For QI-02 B Measures affecting health care cost. Would using medication reconciliation work for that measure. By reviewing the medication list with the patients the providers are able to low the patients cost if they are no longer taking those medication.

NCQA Response:

The intent of QI 02B is for practices to use measures to help them understand how efficiently they're providing care and judiciously using resources. Looking at # of medications prescribed is a good example. I've included additional examples of measures affecting health care costs below. - Total cost per patient - Medical cost per medical visit - Use of high cost medications - Use of imaging for low back pain - Redundant imaging or lab tests - Emergency department utilization - Hospital readmission rates - Use of generic versus brand name medication - # of Specialist referrals - # of patients who went to urgent care during open office hours - # of referrals/ED visits for needs that could be addressed in the office - Appropriate testing for children with pharyngitis - Appropriate treatment for children with URI If you have any further questions please do not hesitate to reach out.

QI-02 B

A clinic runs a fee analyzer that gives them an average of costs for treatment in our area, such as visits, procedures, medications. From that price they typically set their highest fee at 60% of that average. Would that satisfy QI-02 B measures affecting health care cost because their patients are then able to receive health care at a lower cost to them.

NCQA Response:

It sounds like your practice has implemented a process to determine their fees based on the average cost of services in your area, however it is not clear what measure this action is based on. The measure related to cost (QI 02) that led to your practice implementing a fee analyzer (QI 09) is what we're looking for in QI 02B. The intent of QI 02B is for practices to use measures to help them understand how efficiently they're providing care and judiciously using resources.

Some examples of measures affecting health care costs may include but are not limited to: - Total cost per patient - Medical cost per medical visit - # of medications prescribed - Use of high cost medications - Use of imaging for low back pain - Redundant imaging or lab tests - Emergency department utilization - Hospital readmission rates - Use of generic versus brand name medication - # of Specialist referrals - # of patients who went to urgent care during open office hours - # of referrals/ED visits for needs that could be addressed in the office - Appropriate testing for children with pharyngitis - Appropriate treatment for children with URI

QI-02 B

Would either of these work for QI-02B 1. Tracking the number of call that a clinic get after hours and what type of call they are or 2. Looking at how many appointments a clinic has outside normal business hours (morning, evening and weekend appointments).

NCQA response:

No, the examples from your inquiry would not work for QI 02B. However, we do evaluate that practices have a process to respond to call requesting clinical advice in a timely manner for AC 04 and evaluate that practices provide appointments outside of business hours in AC 03. Below is a list of example measures that are appropriate for care coordination (QI 02A) and a list of appropriate measures affecting health care costs (QI 02B).

The intent of QI 02A is to evaluate the communication/coordination that occurs between providers or providers and patients, so it's generally looking at closing the loop on care coordination tasks/processes. Some examples for care coordination may include but are not limited to: - Reduced % of patients seeing multiple providers (3 or more) - Providing a summary of care record to another provider for referrals/care transitions (MU) - Medication reconciliation after care transition (MU) - Receiving a report from a provider to whom the patient was referred, - Follow up with patients or providers to ensure ordered lab or imaging tests were completed - Follow up with patients following receipt of abnormal test results - Outreach to patients not recently seen that result in an appointment - Follow-up phone calls to check on the patient after an ER visit (or hospitalization) - # patient calls received after hours by the call center were reconciled in the patient record and addressed by the care team the next business day - Following up on pediatric visits to after-hours care - Number of referrals sent - % of patients who had a positive TB screen who had a FU Chest x-ray - % of patients who had a positive GC/Chlamydia who were treated with antibiotics

The intent of QI 02B is for practices to use measures to help them understand how efficiently they're providing care and judiciously using resources. Some examples of measures affecting health care costs may include but are not limited to: - Total cost per patient - Medical cost per medical visit - # of medications prescribed - Use of high cost medications - Use of imaging for low back pain - Redundant imaging or lab tests - Emergency department utilization - Hospital readmission rates - Use of generic versus brand name medication - # of Specialist referrals - # of patients who went to urgent care during open office hours - # of referrals/ED visits for needs that could be addressed in the

office - Appropriate testing for children with pharyngitis - Appropriate treatment for children with URI

QI 02

In the 2014 Standards this measure specified “Data provided by an external source (such as a health plan) represent 75 percent of the practice’s eligible population.” I do not see the same language in within the description for QI 02. Are practices still required to use data that represents 75% of the practice’s eligible population”?

NCQA’s response:

Yes, the expectation would be that the data would still represent a majority (>75%) of your patients, if using data from an external source.

QI-02 A & B

I can get some clarification or examples of what measures affect Healthcare cost. Would reducing patient's visits to ED count? What else?

NCQA’s response:

The intent of QI 02B is for practices to use measures to help them understand how efficiently they’re providing care and judiciously using resources. Examples of acceptable measures includes medical cost per medical visit, # of medications prescribed, use of high cost medications, use of imaging for low back pain, redundant imaging or lab tests, emergency department utilization, hospital readmission rates, use of generic vs. brand name medication, # of patients who went to urgent care during open office hours, # of referrals/ED visits for needs that could be addressed in the office. Please note that this is not an exhaustive list, just some accepted health care costs measures.

QI-03

Can I get some additional clarification on what NCQA is looking for on QI-03. I understand third next available appointment, but are there other ways to access performance on availability? For example, if a clinic had x amount of same day appointments blocked out and they monitored how many were filled and by what point of the day they were filled would that satisfy QI-03?

NCQA Response:

In QI 03 NCQA evaluates whether practices assess performance on the availability of major appointment types to meet the access needs of their patients. The practices should set a standard(s) for availability of major appointment types and monitor against their defined standard(s). 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 showing appointment wait times, compared with defined standards. NCQA often points practices to the third next availability appointment since it is typically seen as a better indicator of appointment availability, but it is ultimately up to the practice to determine how to best evaluate appointment availability at their practice. The standard for availability and how the practice monitors against that standard should be in the documented process.

QI: 04 B, 06, 07 and CAHPS

I know that the CAHPS survey is a credit elective for QI-06 but can using the CAHPS survey also satisfy QI-04 A and QI-07?

NCQA Response:

The practice may use the CAHPS survey to satisfy QI 04A and QI 06. The patient experience survey would not meet QI 07, but can be used to identify potential disparities for QI 05B. For QI 07, if the practice has found there are disparities of care or service for a vulnerable patient population at their practice, the practice obtains feedback from the identified vulnerable patient population to determine actions to improve where there are disparities in care or experience. This may be done either through some feedback mechanism (i.e., supplemental survey directed to the identified vulnerable population(s)) or representatives of that identified vulnerable group (i.e., focus groups, interviews, etc.). The intent behind the feedback is to use that information to better develop/support quality improvement activities to address the disparities in care or service. QI 07 is 2 credits because practices are expected to work with the vulnerable population to determine the why or root cause before setting an improvement plan in place. Again, the typical patient experience survey (QI 04A) is not sufficient for QI 07, but could help with identifying a potential disparity for QI 05.

QI 10

Please clarify-does this require setting goals to improve ALL of the major appointment types tracked in QI03? Or does it require setting goals to improve ONE major appointment type of those tracked in QI 03?

NCQA's response:

Yes, only one appointment type needs to be identified. The practice may review their performance on major appointment types in QI 03 to identify an area for improvement and demonstrate that they have set goals and acted to improve upon the identified opportunity to meet QI 10 which may include identifying opportunities to improve same day access. It is ultimately up to the practice to review their appointment availability performance and determine where they would like to focus its activities for improvement but again. The data must compare actual appointment wait time (availability) with the standard specified in the documented process. It is up to the practice to decide what goals to set based on based on areas for improvement identified in QI 03. There is no requirement you must set goals to improve more than one major appointment type, but it would just depend on the practice needs.

QI-15

For criteria QI-15 if a practice shares the individual providers huddles percentages per month (huddles held/ days worked per month) with the providers and the clinic staff to show how often care teams are huddling would that satisfy QI-15?

NCQA's Response:

For QI 15 and QI 16, the practice must share (1) at least one clinical quality measure, at least one resource stewardship AND at least one patient experience measure. The practice may certainly share more measures, it is up to them to determine how much they want to share.

QI15 Reporting Performance

I have a question regarding QI15 on reporting performance. Are practices required to report performance within the practice on all quality measures? In 2014 they were to share at least one example from each category, Clinical Quality Measures, Resource Stewardship, and Patient Satisfaction. Does this direction still apply for QI15?

NCQA's response:

For QI 15 and QI 16, the practice must share (1) at least one clinical quality measure, at least one resource stewardship AND at least one patient experience measure. The practice may certainly share more measures, it is up to them to determine how much they want to share.

QI 19 Upside Risk Contract

Idaho Medicaid Healthy Connections has a Tier systems, depending on the different levels of care and preventative medicine your practice delivers your practice receives higher reimbursements. If your practice fails to do the certain task or stops doing those preventative measures, then you drop down in the tier systems and reimbursement goes down as well. Does this fulfill QI-19 A & B the upside risk contract and two sided risk contract?

NCQA response:

Yes, this would meet the intent of QI 19 A, an upside risk contract. It does not meet QI 19B, but MIPS satisfies QI-19 B.

Further clarification on QI18 and QI19

Good afternoon, Can you give further explanation on QI18 and QI19? Would participating in MIPS/MACRA satisfy the intent for QI18 and QI 19 Part B. Can you provide me a list of other examples that would satisfy these criteria? Thank you for your time!

NCQA's response:

Thank you for your inquiry. A practice can get credit for QI 18 if it's sharing clinical quality measures directly with CMS as long as you report the minimum number of clinical quality measures outlined in the criteria to Medicare or Medicaid through a program like MIPS: • At least one immunization measure. • One preventive care measure (not including immunizations). • One chronic or acute care clinical measure. • One behavioral health measure. The practice may receive credit for QI 19B if the practice is in an Advanced Alternative Payment Model (APM), but not for MIPS. Some other examples that would meet QI 19 would include any agreements with payers that include upside risk or two-sided risk. Some ACOs and IPAs have begun negotiating with payers for these types of agreements so being part of an ACO or IPA that includes these types of agreements would also meet the intent.

HIT Prevalidation for PCMH 2017

Could you tell me when we will know which EHRs have pre-validation credits for the PCMH 2017 recognition.

Answer

Hi Kim: Thank you for your inquiry. It was a pleasure speaking with you this morning about PCMH 2017 vendor prevalidation. You asked about the status of the following 3 vendors: 1) athenahealth now has PCMH Prevalidation credit for both PCMH 2014 and PCMH 2017 2) Practice Fusion just recently received prevalidation for PCMH 2014. We will be contacting them re: PCMH 2017 shortly. 3) Centricity is prevalidated for PCMH 2014 and was sent information re: an opportunity to transfer eligible credit to PCMH 2017. Please contact athenahealth for more information re: their prevalidation. Please check back with us later re: any updates on the other 2 vendors.

Status: Closed

Created: 06/14/2017

Modified: 06/21/2017

Case: 00149658

Subject Areas

Programs

Application/Survey (Recognition)

PCMH - Patient-Centered Medical Home

Comments

Jean Rossi said:

Jun 21 2017

Hi Kim: I tried to call you this morning after not hearing back from you re: my note below. I left a VM on your phone. Please call me at 202 955 3542 or send me an email at rossi@ncqa.org or respond via this message re: what vendor(s) you are inquiring about. Thanks, Jean Rossi