Instructions for Reading the PCMH 2017 Recommendations Table

The PCMH 2017 Recommendations Table details the proposed PCMH 2017 requirements. Table 1 outlines the layout and information.

Refer to the PCMH 2017 Public Comment Overview memo for information on the development process and details about the new program format.

Table 1. PCMH 2017 Recommendations Table Guide

Purpose Statement	Core Criteria	Additional Criteria
1. Category: [A brief title to describe the criteria in the category] **Concept Statement:** [A brief statement that describes the goals, criteria, category intent and requirements]		
A. A brief description of the sub-category requirements.	**CORE:** Requirements for all practices to meet to receive PCMH recognition. These are requirements seen as necessary for a practice to demonstrate it has transformed is functions as a medical home. **CORE DOCUMENTATION** A brief description of the documentation required to meet the Core and Additional Criteria requirements. NCQA also intends to increase flexibility in the methods used for documentation. Practices will have the opportunity to demonstrate they meet some requirements during a virtual review of their practice during the recognition process.	**ADDITIONAL CRITERIA:** A list of important requirements for practices to demonstrate but practices must only demonstrate a portion of the listed items. Practices can choose among the items to tailor their activities to the community and population served. Requirements noted as **(ADVANCED)** are requirements that are more challenging and are above and beyond typical practice function and capabilities. **ADDITIONAL CRITERIA DOCUMENTATION** A brief description of the documentation required to meet the Core and Additional Criteria requirements. NCQA also intends to increase flexibility in the methods used for documentation. Practices will have the opportunity to demonstrate they meet some requirements during a virtual review of their practice during the recognition process.

Additional Instructions

- The number for each Core criteria is continuous from "1" and does not reset.
- Additional Criteria items are labeled with "A" (*for example:* A1). Numbering is continuous from "1" and does not reset. Practices are expected to complete a certain number of Additional Criteria items across the entire program.
- Items new to the PCMH requirements will be <u>underlined</u> so it is clear what was an existing versus new item.

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
1. Team-Based Care and Practice Organization **CONCEPT STATEMENT:** The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers and organizes and trains staff to work to The top of their license and ability to provide effective team-based care.		
A. The PCMH model requires significantly different allocation of resources and a practice wide commitment to sustaining the transformation of the practice. While it is important to have a champion leading the effort, it is also important for all members of the practice team and the leadership that controls resource allocation to understand and embrace the culture change.	**CORE** 1. Defines practice organizational structure and staff responsibilities to support key PCMH functions.. 2. Has a designated clinician leader that supports the PCMH model. **CORE DOCUMENTATION** Criterion 1: Staff structure overview. Criterion 2: Identifies clinician leader (i.e., name, position description).	**ADDITIONAL CRITERIA** A1. Attests that ownership of the organization is committed to PCMH model. **(ADVANCED)** A2. Leadership supports participation in external collaborative activities (e.g., federal/state initiatives, health information exchanges.) **(ADVANCED)** A3. Patients are involved in the practice's governance structure or on stakeholder committees. **(ADVANCED)** A4. The practice uses an EHR system (or modules) that has been certified and issued a CMS Certification ID. **(ADVANCED)** A5. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A1-A2: Describe how ownership/ leadership support the activity. A3: Documented process. A4-A5: Identifies system(s) implemented and attests to security activities..
B. Members of the care team serve specific roles as defined by the practice organizational structure and should be equipped with the knowledge and training necessary to perform those functions. Staff communication must be structured to ensure effective, coordinated and safe patient care. Staff must be	**CORE** 3. Involves care team staff in the practice's performance evaluation and quality improvement activities. 4. Has regular patient care team meetings or a structured communication process focused on individual patient care. 5. Identifies relevant skills or resources required to support team member roles and ensure skills and training are maintained. (Practice must demonstrate at least 3): A. Training and assigning members of the care team to coordinate care for individual patients.	**ADDITIONAL CRITERA** A6. Has at least one care manager qualified to identify and coordinate behavioral health needs. **(ADVANCED)** A7. Has at least one clinician providing medication-assisted treatment (MAT), and providing behavioral therapy directly or via referral, for substance use disorder. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A6: Identifies staff supporting behavioral health care management including qualifications. .

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
trained to effectively function in their defined roles.	B. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change (i.e. brief action planning). C. Training and assigning members of the care team to conduct on-going population management activities. D. Training and assigning members of the care team for care management. **CORE DOCUMENTATION** Criterion 3: Documented process or staff descriptions Criterion 4: Documented process and evidence Criterion 5: Documented process or staff descriptions **AND** materials	A7: Example of active MAT and behavioral therapy for at least one de-identified patient.
C. The PCMH model seeks to provide patient-centered, coordinated, comprehensive care with an emphasis on improving quality and patient experience and lowering costs. Practice communicates and engages patients on expectations and their role in the medical home model of care.	**CORE** 6. Communicates roles and responsibilities of both the practice staff and patients/families/caregivers as part of the medical home model. **CORE DOCUMENTATION** Criterion 6: Materials and description of communication process.	**ADDITIONAL CRITERIA** None **ADDITIONAL CRITERIA DOCUMENTATION** None
2. Knowing and Managing Your Patients **CONCEPT STATEMENT:** The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.		
A. Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals.	**CORE** 7. Documents patient demographic information as structured data (Practices MUST respond to at least 5 criteria): A. Preferred language. B. Legal guardian C. Patient e-mail address D. Primary caregiver E. Alternative caregiver(s) F. Patient occupation (NA for pediatric practices) G. Name of other health care professionals involved in patient's care	**ADDITIONAL CRITERIA** A8. Documents social determinants of health for patients, monitors at the population level and implements care based on these data. **(ADVANCED)** A9. Depression screening for adults and adolescents using a standardized tool. A10. Anxiety screening for adults, adolescents and children using a standardized tool. A11. Substance Use Disorder screening for adults and adolescents using a standardized tool. A12. Developmental screening using a standardized tool. (NA for practices with no pediatric population.)

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	8. Documents patient up-to-date problem list with current and active diagnoses. 9. Comprehensive health assessment (practice must select at least 6): A. Family/social/cultural characteristics. B. Social functioning C. Communication needs. D. Medical history of patient and family. E. Advance care planning. (NA for pediatric practices) F. Behaviors affecting health. G. Mental health/substance use history of patient and family H. Social Determinants of Health (NEW) **CORE DOCUMENTATION** Criterion 7: Report **OR** documented process and examples **OR meets A13**. Criterion 7: Report **OR** documented process and examples **OR meets A9**. Criterion 9: Report **OR** documented process and examples.	A13. Identifies the predominant conditions and health concerns of the patient population. **(ADVANCED)** A14. Evaluates patient demographics, preferences, health literacy to tailor development and distribution of patient materials. **(ADVANCED)** A15. Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines. **(ADVANCED)** A16. Demonstrates advanced clinical processes using a certified EHR to enhance population health management. A17. Uses identified health disparities to tailor population health management. **(ADVANCED)** A18. Addresses health literacy needs of the practice at the population level (e.g., universal precautions, teach back method, medication brown bag, use of plain language) **ADDITIONAL CRITERIA DOCUMENTATION** A8: Documented process and examples. A9-12: Report or documented process **AND** patient examples. A13: Documented process and list identifying top priority conditions and concerns. A14,15,17: Documented process and examples. A16: Demonstration of use A18: Examples or materials
B. The PCMH model encourages practices to have a hands-on approach to patient care. The practice takes a proactive approach to reminding patients of needed services to address patient preventive and acute care needs.	**CORE** 10. Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (practice must report at least 3 categories): A. Preventive care services. B. Immunizations. C. Chronic or acute care services. D. Patients not recently seen by the practice. **CORE DOCUMENTATION** Criterion 10: List of patients and outreach materials; Practices meeting A19 receive credit for 4C.	**ADDITIONAL CRITERIA** A19. Demonstrates excellence in provision of evidence-based care. [Allow performance measures to substitute for reminder process.] **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A19: Performance Measures reported to NCQA using standardized format **OR** HSRP or DRP Recognition for at least 75% of clinicians.

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C. Practice addresses medication safety and adherence by providing information and establishing processes for medication documentation, reconciliation and assessment of barriers.	**CORE** 11.Reviews and reconciles medications for more than 80 percent of patients received from care transitions 12. Assesses understanding of medications for more than 50 percent of patients/families/ caregivers, and dates the assessment 13.Assesses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment 14.Maintains an up-to-date drug list. **CORE DOCUMENTATION** Criterion 11-13: Report Criterion 14: Report **OR** documented process and examples	**ADDITIONAL CRITERIA** A20. Medication reconciliation for behavioral health. **(ADVANCED)** A21. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers. A22. Demonstrates a process within the organization to educate more than 80 percent of patients/families/caregivers on new prescriptions. A23. Documents nonprescription medication for more than 50 percent of patients, and dates updates A24. Systematically obtains prescription claims data in order to assess and address medication adherence. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A20: Report **OR** documented process and example. A21-23: Report A24: Report **OR** Example
D. Practice incorporates evidence-based clinical decision support across a variety of conditions and circumstances to ensure effective and efficient care is provided to patients.	**CORE** 15. Implements clinical decision support following evidence-based guidelines for: (Practice must demonstrate at least 4 criteria.) A. Mental health/substance use B. A chronic medical condition C. An acute condition D. A condition related to unhealthy behaviors E. Well child or adult care F. Overuse/appropriateness issues **CORE DOCUMENTATION** Criterion 15: Conditions identified, source of guidelines **and** examples	**ADDITIONAL CRITERIA** None **ADDITIONAL CRITERIA DOCUMENTATION** None
E. The practice provides information and establishes connections to community resources to collaborate and direct patients to for care support.	**CORE** 16. Identifies and prioritizes most relevant community resources based on assessment of social determinants and common conditions. 17. Maintains a current resource list on five topics or key community service areas of importance to the patient population including	**ADDITIONAL CRITERIA** A25. Provides educational materials and resources to patients, including online support programs. A26. Provides oral health resources to patients. A27. Provides self-management tools to record self-care results.

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
	services offered outside the practice and its affiliates based on community resource priority list. **CORE DOCUMENTATION** Criterion 16: Documented process and prioritized list of topics or key community service areas. Criterion 17: Materials OR **meets A30**.	A28. Adopts shared decision making aids for preference-sensitive conditions. A29. Offers or refers patients to structured health education programs such as group classes and peer support. A30. Assesses usefulness of identified community resources.**(ADVANCED)** A31. Works with community schools or urban intervention agencies. A32. Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).) **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A25-29: Three examples of resources, tools or aids A30. Documented process, example or other means of demonstration A31: Agreement **OR** description of relationship and materials A32: Documented process and patient example

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
3. Patient-Centered Access and Continuity **CONCEPT STATEMENT**: Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.		
A. The PCMH model seeks to enhance access by providing appointments and clinical advice based on the patient's needs. In addition to being key to patient-centeredness, evidence explicitly supports that providing enhanced access including same-day, extended hours and telephone advice from clinicians with access to the patient record reduces ED visits and hospitalizations.	**CORE** 18. Provides same-day appointments for routine and urgent care. 19. Provides routine and urgent-care appointments outside regular business hours. 20 Assesses performance on availability of appointments and adjusts to meet patient needs and preferences. 21. Provides timely clinical advice by telephone. 22. Documents clinical advice in patient records. 23. Assesses the access needs and preferences of the patient population. **CORE DOCUMENTATION** Criterion 18: Documented process and 5-day schedule Criterion 19: Documented process **AND** 5-day schedule or Materials Criterion 20: Documented process **AND** report demonstration of assessing appointment availability Criterion 21: Documented process and 7-day report Criterion 22: Documented process and 3 examples (1 during office hours, 1 after hours, third their choice) Criterion 23: Documented process **AND** report or example of assessing patient access needs and preferences (i.e. survey, patient interviews, comment box)	**ADDITIONAL CRITERIA** A33. Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms. A34. Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results. **(ADVANCED)** A35. Provides timely clinical advice using a secure, interactive electronic system. A36. Has a secure electronic system for two-way communication. **(ADVANCED)** A37. Has a secure electronic system so patients can view, and are provided the capability to download, their health information or transmit their health information to a third party. **(ADVANCED)** A38. Evaluates the number of patients assigned to each clinician's panel. A39. Evaluates identified health disparities to assess access across the patient population. A40. Evaluates social determinants to assess access for individual patients. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A33: Documented process **AND** 30-day report or schedule A34: Web pages or demonstration of capability A35: Documented process and 7-day report A36: Demonstration of capability A37: Report or demonstration of capability A38: Report, with the number of patients assigned to each clinician A39: Report or examples A40: Report or examples

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B. The PCMH model expects continuity of care. Practices demonstrate continuity through empanelment and access to the patient's medical record.	**CORE** 24. Helps patients/families select or change a personal clinician 25. Monitors the percentage of patient visits with selected clinician or team. 26. Provides continuity of medical record information for care and advice when the office is closed **CORE DOCUMENTATION** Criterion 24: Documented process Criterion 25: Report Criterion 26: Documented process	**ADDITIONAL CRITERIA** A41. Demonstrates a systematic process for monitoring and balancing the active patient panel of each clinician/team. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A41: Documented process
C. The PCMH model seeks to provide patient-centered, coordinated, comprehensive care with an emphasis on improving quality and patient experience and lowering costs. Practice informs patients on what they can expect from the practice and their role in the medical home.	**CORE** 27. Has a process to orient new patients to the practice and provide existing patients with information about the medical home (choose 4 of 7, including A): A. Informs patients/families how to obtain care and clinical advice during office hours and when the office is closed. B. Informs patients/families who is responsible for coordinating patient care across multiple settings. C. Informs patients/families that the practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice. D. Informs patients/families that the care team provides access to evidence-based care, patient/family education and self-management support. E. Informs patients/families of the practice's scope of services available within the practice including how behavioral health needs are addressed. F. Informs patients/families of instructions on transferring records to the practice, including a point of contact at the practice. G. Informs patients/families that the practice gives uninsured patients information about obtaining coverage. **CORE DOCUMENTATION** Criterion 27: Documented process **AND** materials or demonstration of orientation	**ADDITIONAL CRITERIA** None **ADDITIONAL CRITERIA DOCUMENTATION** None

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
D. The PCMH model seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.	**CORE** 28. Assesses the diversity (race, ethnicity, one other aspect of diversity) of its population. 29. Assesses the language needs of its population. **CORE DOCUMENTATION** Criteria 28, 29: Reports	**ADDITIONAL CRITERIA** None **ADDITIONAL CRITERIA DOCUMENTATION** None
4. Care Management and Support **CONCEPT STATEMENT:** The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.		
A. The PCMH model seeks to improve quality of care, smarter spending, and health of the population. The practice identifies patients that would benefit most from care management.	**CORE** 30. Considers the following in establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions. B. High cost/high utilization. C. Poorly controlled or complex conditions. D. Social determinants of health. E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver. 31. Monitors the percentage of the total patient population identified through its process and criteria. **CORE DOCUMENTATION** Criterion 30: Criteria for identifying patients for care management **OR A42** Criterion 31: Report with numerator and denominator	**ADDITIONAL CRITERIA** A42. Demonstrates comprehensive risk-stratification of entire patient panel in order to direct resources appropriately and provide care planning and management to patients that would most benefit from those services. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A42: Report demonstrating risk stratification and key conditions/ circumstances of focus
B. The practice uses patient information and collaborates with patients to develop care plans that address barriers and incorporates patient preferences and goals.	**CORE** 32. Identifies treatment goals in individual care plans for at least 75 percent of patients identified for care management based on evidence-based guidelines. 33. Provides written care plan to the patient/family/ caregiver for at least 75 percent of patients identified for care management.	**ADDITIONAL CRITERIA** A42. Incorporates patient preferences and functional/lifestyle goals in individual care plans for at least 75 percent of patients identified for care management. A43. Assesses and addresses potential barriers to meeting goals in individual care plans for at least 75 percent of patients identified for care management.

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
	CORE DOCUMENTATION Criteria 32, 33: Report based on patients identified for care management	A44. Includes a self-management plan in individual care plans for at least 75 percent of patients identified for care management. A45. Collaborates with the patient/family to develop/implement a written care plan for complex patients transitioning from pediatric care to adult care. A46. Follows up on community referrals to determine impact on individual patients.(ADVANCED) **ADDITIONAL CRITERIA DOCUMENTATION** A42-44: Report based on patients identified for care management A45: Documented process **AND** examples or materials A46: Documented process **AND** report, log or other demonstration of follow-up
5. Care Coordination and Care Transitions **CONCEPT STATEMENT:** The practice tracks tests, referrals and care transitions to ensure comprehensive care coordination and communication with specialists and other providers in the medical neighborhood.		
A. The PCMH model seeks to achieve high quality and lower costs by effective management of laboratory/imaging tests and referrals. The practice monitors all lab tests and imaging to completion and informs patients of the results.	**CORE** 34. Tracks lab tests until results are available, flagging and following up on overdue results. 35. Tracks imaging tests until results are available, flagging and following up on overdue results. 36. Flags abnormal lab results, bringing them to the attention of the clinician. 37. Flags abnormal imaging results, bringing them to the attention of the clinician. 38. Notifies patients/families of normal lab and imaging test results. 39. Notifies patients/families of abnormal lab and imaging test results. **CORE DOCUMENTATION** Criteria 34-39: Documented process **AND** evidence showing how the process is met for each criteria, such as report, a log, examples, or electronic tracking system (to receive credit for the factor, the practice must show evidence across patients, not just a single example)	**ADDITIONAL CRITERIA** A47. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults). **ADDITIONAL CRITERIA DOCUMENTATION** A47: Documented process **AND** evidence showing how the process is met

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
B. The PCMH model seeks to improve communication for patient referrals. The practice provides comprehensive information in referrals to specialists and tracks referrals until the report is received.	**CORE** 40. Gives the consultant or specialist the clinical question, the required timing and the type of referral. 41. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan. 42. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. 43. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit. **CORE DOCUMENTATION** Criteria 40-42: Documented process **AND** evidence showing how the process is met for each criteria, such as report, a log, examples, or electronic tracking system (to receive credit for the factor, the practice must show evidence across patients, not just a single example) Criterion 43: Documented process **AND** evidence of follow up or a log documenting systematic follow-up	**ADDITIONAL CRITERIA** A48. Uses evidence-based guidelines to determine when a referral to a specialist is necessary. A49. Reviews and identifies commonly referred specialty practices for patient referrals. A50. Considers available performance information on consultants/specialists when making referral recommendations. **(ADVANCED)** A51. Works with frequently referring clinicians to set expectations for information sharing and patient care. A52. Has agreements with a subset of specialists. A53. Maintains agreements with behavioral healthcare providers. A54. Monitors depression over time and provides or refers for intervention if the patient does not improve. **(ADVANCED)** A55. Tracks behavioral health referrals. **(ADVANCED)** A56. Integrates behavioral healthcare providers within the practice site. **(ADVANCED)** A57. Monitors referrals by specialty type. A58. Monitors the completeness and quality of the referral response. A59. Documents co-management arrangements in the patient's medical record. A60. Asks patients/families about self-referrals and requesting reports from clinicians. A61. Engages with patients regarding costs implications of treatment options. **(ADVANCED)**. **ADDITIONAL CRITERIA DOCUMENTATION** A48: Demonstration of guideline sources and decision support A49: Report, log or tracking system A50: Examples of the type of information the practice team has available on specialist performance. A51: Materials and description of activities A52, A53: At least one example A54: Three patient examples

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
		A55: Documented process **AND** evidence showing how the process is met, such as a report, a log, examples or electronic tracking system (to receive credit for the factor, the practice must show evidence across patients, not just a single example) A56: Documented process and materials A57: Report, log or tracking system A58: Three patient examples or evidence of monitoring A59-60: Three patient examples A61: Documented process and materials
C. The PCMH model seeks to connect practices with other care facilities to support safe patient care throughout care transitions. The practice receives and shares necessary patient treatment information to provide comprehensive patient care.	**CORE** None **CORE DOCUMENTATION** None	**ADDITIONAL CRITERIA** A62. Systematic ability to connect and coordinate with acute care settings after hours. A63. Proactively identifies patients with unplanned hospital admissions and emergency department visits. A64. Shares clinical information with admitting hospitals and emergency departments. A65. Exchanges patient information with the hospital during a patient's hospitalization. A66. Demonstrates the capability to electronically exchange information with external entities, agencies and registries (may select 1 or more): **(ADVANCED)** A. Regional health information organization (RHIPO) or other information source that enhances ability to manage complex patients. **(ADVANCED)** B. Immunization registries or immunization information systems. **(ADVANCED)** C. Health information exchange. **(ADVANCED)** D. Summary of care record to another provider or care facility for care transitions. **(ADVANCED)** A67. Consistently obtains patient discharge summaries from the hospital and other facilities. **ADDITIONAL CRITERIA DOCUMENTATION** A62: Documented process **AND** patient examples or materials A63: Documented process **AND** a log or a report A64: Documented process and three examples

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
		A65: Documented process and three patient examples demonstrating exchange of information A66: Demonstration of capability A67: Documented process and three patient examples
6. Performance Measurement and Quality Improvement **CONCEPT STATEMENT:** The practice collects, reports and uses performance data to identify opportunities for quality improvement, sets goals and acts to improve clinical quality, efficiency, patient experience and engages the staff and patients/families/caregivers in the quality improvement activities.		
A. The practice establishes a culture of quality improvement. Practice measures to understand current performance and analyzes performance data to identify opportunities to improve.	**CORE** 44. Measures clinical quality for at least five measures across the four categories. A. Immunization measures B. Other preventive care measures C. Chronic or acute care clinical measures D. Behavioral health measures 45. Sets goals and acts to improve upon at least five measures across the four categories. A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures. 46. Measures at least two measures of resource stewardship. A. Measures related to care coordination. B. Measures affecting health care costs. 47. Sets goals and acts to improve upon at least one measure of resource stewardship. A. Measures related to care coordination. B. Measures affecting health care costs. 48. Sets goals and acts to improve upon identified opportunities to improve access. **CORE DOCUMENTATION** Criterion 44: Reports **OR meets A70.** Criterion 46: Reports Criterion 45, 47, 48:Reports ***or*** Quality Improvement Worksheet	**ADDITIONAL CRITERIA** A68. Reports clinical quality measures to Medicare or Medicaid agency across the four measure groups in A-D. **(ADVANCED)** A69. Assessing health disparities (may select 1 or more): **(ADVANCED)** A. Performance data stratified for vulnerable populations (to assess disparities in care). **(ADVANCED)** B. Achieves improvement on a measure with an identified disparity **(ADVANCED)** A70. Continuous Quality Improvement. **(ADVANCED)** A. Measuring the effectiveness of the actions it takes to improve the measures selected for Performance Measurement. **(ADVANCED)** B. Achieving improved performance on at least 2 measures. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A68: Reports A69, A70: Reports or Quality Improvement Worksheet

Purpose Statement	Core Criteria and Documentation	Additional Criteria and Documentation
B. The PCMH model expects practices to implement strategies to improve patient experience by collecting patient feedback. The practice adopts transparency and shares performance data with the practice, patients and/or publicly.	**CORE** 49. Collects comprehensive patient experience data on dimensions, such as Access, Communication, Coordination, Whole person care/self-management support A. The practice conducts a survey (using any instrument) to evaluate patient/family experiences. B. The practice obtains feedback from patients/families through qualitative means 50. Sets goals and acts to improve on at least one patient experience measure. 51. Reports practice-level or individual clinician performance results within the practice, publicly or with patients **CORE DOCUMENTATION** Criterion 49A:Reports **OR meets A71 or A72** Criterion 49B: Reports **OR A74** Criterion 50:Reports **OR** Quality Improvement Worksheet Criterion 51:Reports ***and*** explanation	**ADDITIONAL CRITERIA** A71. The practice uses a standardized survey tool. **(ADVANCED)** A72. The practice reports patient experience using an NCQA certified survey vendor and standardized sampling and methodology, and reports results to NCQA. **(ADVANCED)** A73. The practice obtains feedback on experiences of vulnerable patient groups. **(ADVANCED)** A74. Involves patient/family/caregiver in quality improvement activities. **(ADVANCED)** A75. The practice obtains feedback from a patient family advisory council. **(ADVANCED)** A76. Continuous Quality Improvement A. Measuring the effectiveness of the actions it takes to improve the measures selected for Performance Measurement. **(ADVANCED)** B. Achieving improved performance on at least 1 measure. **(ADVANCED)** **ADDITIONAL CRITERIA DOCUMENTATION** A71-A73, A75: Report A74: Documented process A76: Reports or Quality Improvement Worksheet