CROSSWALK: CHANGE CONCEPTS FOR PRACTICE TRANSFORMATION AND 2014 NCQA PCMH™ RECOGNITION STANDARDS

ENGAGED LEADERSHIP

Change Concept Element	2014 NCQA PCMH Standards
1a. Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 8. Holding scheduled team meetings to address practice functioning
1b. Ensure that the PCMH transformation effort has the time and resources needed to be successful.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Holding regular patient care team meetings or a structured communication process focused on individual patient care 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning
1c. Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST PASS)** *The practice uses a team to provide a range of patient care services by:* 3. Holding regular patient care team meetings or a structured communication process focused on individual patient care 8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities

	Change Concept Element	2014 NCQA PCMH Standards
ENGAGED LEADERSHIP	1d. Build the practice's values on creating a medical home for patients into staff hiring and training processes.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities
QUALITY IMPROVEMENT STRATEGY	2a. Choose and use a formal model for quality improvement.	**PCMH 6: Performance Measurement and Quality Improvement,** **Element D: Implement Continuous Quality Improvement (MUST PASS)** *The practice uses an ongoing quality improvement process to:* 1. Set goals and analyze at least 3 clinical quality measures from Element A 2. Act to improve at least 3 clinical quality measures from Element A 3. Set goals and analyze at least 1 measure from Element B 4. Act to improve at least 1 clinical measure from Element B 5. Set goals and analyze at least 1 patient experience measure from Element C 6. Act to improve at least 1 patient experience measure from Element C 7. Set goals and address at least 1 identified disparity in care/service for identified vulnerable populations **Element E: Demonstrate Continuous Quality Improvement** *The practice demonstrates continuous quality improvement by:* 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 2. Achieving improved performance on at least 2 clinical quality measures 3. Achieving improved performance on one utilization or care coordination measure 4. Achieving improved performance on at least one patient experience measure

	Change Concept Element	2014 NCQA PCMH Standards
QUALITY IMPROVEMENT STRATEGY	2b. Establish and monitor metrics to evaluate routine improvement efforts and outcomes; ensure all staff members understand the metrics for success.	**PCMH 6: Performance Measurement and Quality Improvement,** **Element A: Measure Clinical Quality Performance** *At least annually, the practice measures or receives data on:* 1. At least 2 immunization measures 2. At least 2 other preventive care measures 3. At least 3 chronic or acute care clinical measures 4. Performance data stratified for vulnerable populations (to assess disparities in care) **Element B: Measure Resource Use and Care Coordination** *At least annually, the practice measures or receives quantitative data on:* 1. At least 2 measures related to care coordination 2. At least 2 measures affecting health care costs **Element C: Measure Patient/Family Experience** *At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.* 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least 3 of the following categories: • Access • Communication • Coordination • Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS Clinician and Group Survey Tool 3. The practice obtains feedback on the experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means **Element D: Implement Continuous Quality Improvement (MUST PASS)** *The practice uses an ongoing quality improvement process to:* 1. Set goals and analyze at least 3 clinical quality measures from Element A 2. Act to improve at least 3 clinical quality measures from Element A 3. Set goals and analyze at least 1 measure from Element B 4. Act to improve at least 1 clinical measure from Element B 5. Set goals and analyze at least 1 patient experience measure from Element C 6. Act to improve at least 1 patient experience measure from Element C 7. Set goals and address at least 1 identified disparity in care/service for identified vulnerable populations

	Change Concept Element	2014 NCQA PCMH Standards
QUALITY IMPROVEMENT STRATEGY	2b. Establish and monitor metrics to evaluate routine improvement efforts and outcomes; ensure all staff members understand the metrics for success.	**Element E: Demonstrate Continuous Quality Improvement** *The practice demonstrates continuous quality improvement by:* 5. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 6. Achieving improved performance on at least 2 clinical quality measures 7. Achieving improved performance on one utilization or care coordination measure 8. Achieving improved performance on at least one patient experience measure **Element F: Report Performance** *The practice produces performance data reports using measures from Elements A, B and C and shares:* 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice **PCMH 1: Patient-Centered Access,** **Element A: Patient-Centered Appointment Access (MUST PASS)** *The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:* 1. Providing same-day appointments for routine and urgent care 2. Providing routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting on identified opportunities to improve access **PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 2. Monitoring the percentage of patient visits with selected clinician or team **PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST PASS)** *The practice uses a team to provide a range of patient care services by:* 9. Involving care team staff in the practice's performance evaluation and quality improvement activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council

	Change Concept Element	2014 NCQA PCMH Standards
QUALITY IMPROVEMENT STRATEGY	2c. Ensure that patients, families, providers and care team members are involved in quality improvement activities.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 9. Involving care team staff in the practice's performance evaluation and quality improvement activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council **PCMH 6: Performance Measurement and Quality Improvement,** **Element F: Report Performance** *The practice produces performance data reports using measures from Elements A, B and C and shares:* 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice 3. Individual clinician or practice-level performance results publicly 4. Individual clinician or practice-level performance results with patients
	2d. Optimize use of health information technology to meet Meaningful Use criteria.	All Meaningful Use Stage 2 requirements, both core and menu, are embedded within the NCQA 2014 PCMH Standards and Guidelines (1C1-4; 3A1-5; 3B1-8, 10 and 11; 3D1-3; 3E stem; 4C1; 4D1-3; 4E1; 5A7-10; 5B7; 5C7; 6G1-7 and 10.)

	Change Concept Element	2014 NCQA PCMH Standards
EMPANELMENT	3a. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.	**PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team
	3b. Assess practice supply and demand, and balance patient load accordingly.	**PCMH 1: Patient-Centered Access,** **Element A: Patient-Centered Appointment Access (MUST PASS)** *The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:* 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting to identify opportunities to improve access **PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 2. Monitoring the percentage of patient visits with selected clinician or team

	Change Concept Element	2014 NCQA PCMH Standards
EMPANELMENT	3c. Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.	**PCMH 3: Population Health Management,** **Element A: Patient Information (All factors)** **Element B: Clinical Data (All factors)** **Element C: Comprehensive Health Assessment (All factors)** **Element D: Use Data for Population Management (MUST PASS) (All factors)** **PCMH 4:Care Management Support,** **Element A: Identify Patients for Care Management** *The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:* 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria

	Change Concept Element	2014 NCQA PCMH Standards
CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS	4a. Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning
	4b. Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.	**PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team

	Change Concept Element	2014 NCQA PCMH Standards
CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS	4c. Ensure that patients are able to see their provider or care team whenever possible.	**PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 2. Monitoring the percentage of patient visits with selected clinician or team **PCMH 1: Patient-Centered Access,** **Element A: Patient-Centered Appointment Access (MUST PASS)** *The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:* 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments
	4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.	**PCMH 2: Team-Based Care,** **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning

	Change Concept Element	2014 NCQA PCMH Standards
ORGANIZED, EVIDENCE-BASED CARE	5a. Use planned care according to patient need.	**PCMH 3: Population Health Management,** **Element E: Implement Evidence-Based Decision Support** *The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for:* 1. A mental health or substance use disorder 2. A chronic medical condition 3. An acute condition 4. A condition related to unhealthy behaviors 5. Well child or adult care **PCMH 4:Care Management Support,** **Element A: Identify Patients for Care Management** *The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:* 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support (MUST PASS)** *The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in* **Element A:** 1. Incorporating patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/caregiver

	Change Concept Element	2014 NCQA PCMH Standards
ORGANIZED, EVIDENCE-BASED CARE	5b. Identify high-risk patients and ensure they are receiving appropriate care and case management services.	**PCMH 4:Care Management Support,** **Element A: Identify Patients for Care Management** *The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:* 7. Behavioral health conditions 8. High cost/high utilization 9. Poorly controlled or complex conditions 10. Social determinants of health 11. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 12. The practice monitors the percentage of the total patient population identified through its process and criteria **Element B: Care Planning and Self-Care Support** *The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in* **Element A:** 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/caregiver **Element C: Medication Management** *The practice has a process for managing medications, and systematically implements the process in the following ways:* 1. Reviews and reconciles medications for more than 50% of patients received from care transitions 2. Reviews and reconciles medications with patients/families for more than 80% of patients of care transitions 3. Provides information about new prescriptions to more than 80% of patients/families/caregivers 4. Assesses understanding of medications for more than 50% of patients/families/caregivers, and dates the assessment 5. Assesses response to medications and barriers to adherence for more than 50% of patients, and dates the assessment 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50% of patients, and dates updates

	Change Concept Element	2014 NCQA PCMH Standards
ORGANIZED, EVIDENCE-BASED CARE	5b. Identify high-risk patients and ensure they are receiving appropriate care and case management services.	**PCMH 2: Team-Based Care,** **Element B: Medical Home Responsibilities** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 5. The scope of services available within the practice including how behavioral health needs are addressed
	5c. Use point-of-care reminders based on clinical guidelines.	**PCMH 3: Population Health Management,** **Element E: Implement Evidence-Based Decision Support** The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder 2. A chronic medical condition 3. An acute condition 4. A condition related to unhealthy behaviors 5. Well child or adult care
	5d. Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.	**PCMH 2: Team-Based Care,** **Element B:** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice 8. Instructions on transferring records to the practice, including a point of contact at the practice **Element D: The Practice Team (MUST-PASS)** *The practice uses a team to provide a range of patient care services by:* 1. Defining roles for clinical and nonclinical team members 3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 7. Training and assigning members of the care team to manage the patient population **PCMH 3: Population Health Management,** **Element A: Patient Information (All factors)** **Element B: Clinical Data (All factors)** **Element C: Comprehensive Health Assessment (All factors)**

	Change Concept Element	2014 NCQA PCMH Standards
PATIENT-CENTERED INTERACTIONS	6a. Respect patient and family values and expressed needs.	**PCMH 2: Team-Based Care,** **Element C: Culturally and Linguistically Appropriate Services** *The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:* 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support (MUST PASS)** *The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in* **Element A:** 1. Incorporating patient preferences and functional/lifestyle goals **Element E: Support Self-Care and Shared Decision Making** *The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:* 4. Adopts shared decision making aids

	Change Concept Element	2014 NCQA PCMH Standards
PATIENT-CENTERED INTERACTIONS	6b. Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.	**PCMH 2: Team-Based Care,** **Element B:** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 4. The care team provides access to evidence-based care, patient/family education and self-management support **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support (MUST PASS)** *The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in* **Element A:** 6. Incorporating patient preferences and functional/lifestyle goals 7. Identifies treatment goals 8. Assesses and addresses potential barriers to meeting goals 9. Includes a self-management plan 10. Is provided in writing to the patient/family/caregiver
	6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.	**PCMH 2: Team-Based Care,** **Element C: Culturally and Linguistically Appropriate Services** *The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:* 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population **Element D: The Practice Team** *The practice uses a team to provide a range of patient care services by:* 7. Training and assigning members of the care team to manage the patient population

	Change Concept Element	2014 NCQA PCMH Standards
PATIENT-CENTERED INTERACTIONS	6d. Provide self-management support at every visit through collaborative goal setting and patient action planning.	**PCMH 2: Team-Based Care,** **Element B:** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 4. The care team provides access to evidence-based care, patient/family education and self-management support **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support** *The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in* **Element A:** 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/caregiver **Element E: Support Self-Care and Shared Decision Making** *The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:* 1. Uses an EHR to identify patient-specific education resources and provide them to ore than 10% of patients 2. Provides educational materials and resources to patients 3. Provides self-management tools to record self-care results 4. Adopts shared decision making aids 5. Offers or refers patients to structured health education programs, such as group classes and peer support 6. Maintains a current resource list on 5 topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources

	Change Concept Element	2014 NCQA PCMH Standards
PATIENT-CENTERED INTERACTIONS	6e. Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.	**PCMH 2: Team-Based Care,** *The practice uses a team to provide a range of patient care services by:* 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council **PCMH 6: Performance Measurement and Quality Improvement,** **Element C: Measure Patient/Family Experience** *At least annually, the practice obtains feedback from patients/families on their experiences with the practice and there are.* 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least 3 of the following categories: • Access • Communication • Coordination • Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS Clinician and Group Survey Tool 3. The practice obtains feedback on the experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means

	Change Concept Element	2014 NCQA PCMH Standards
ENHANCED ACCESS	7a. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email or in-person visits.	**PCMH 1: Patient-Centered Access,** **Element A: Patient-Centered Appointment Access (MUST PASS)** *The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:* 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting to identify opportunities to improve access **Element B: 24/7 Access to Clinical Advice** *The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:* 1. Providing continuity of medical record information for care and advice when office is closed 2. Providing timely clinical advice by telephone 3. Providing timely clinical advice using a secure, interactive electronic system **Element C: Electronic Access** *The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system* 1. More than 50% of patients have online access to their health information within 4 business days of when the information is available to the practice 2. More than 5% of patients view, and are provided the capability to download, their health information to a third party 4. A secured message was sent to more than 5% of patients 5. Patients have two-way communication with the practice 6. Patients can request appointments, prescription refills, referrals and test results **PCMH 2: Team-Based Care,** **Element B: Medical Home Responsibilities** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed

ENHANCED ACCESS

Change Concept Element	2014 NCQA PCMH Standards
7b. Provide scheduling options that are patient- and family centered and accessible to all patients.	**PCMH 1: Patient-Centered Access,** **Element A: Patient-Centered Appointment Access (MUST PASS)** *The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:* 1. Providing same-day appointments for routine and urgent care 2. Providing access to routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters **Element C: Electronic Access** *The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system* 1. A secured message was sent to more than 5% of patients 2. Patients have two-way communication with the practice 3. Patients can request for appointments, prescription refills, referrals and test results **PCMH 2: Team-Based Care,** **Element B: Medical Home Responsibilities** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 6. The practice provides equal access to all of their patients regardless of source of payment
7c. Help patients attain and understand health insurance coverage.	**PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 3. Having a process to orient new patient to the practice **PCMH 2: Team-Based Care,** **Element B: Medical Home Responsibilities** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 6. The practice provides equal access to all of their patients regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage

CARE COORDINATION

Change Concept Element	2014 NCQA PCMH Standards
8a. Link patients with community resources to facilitate referrals and respond to social service needs.	**PCMH 4: Care Management and Support,** **Element E: Support Self-Care and Shared Decision Making** *The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:* 5. Offers or refers patients to structured health education programs, such as group classes and peer support 6. Maintains a current resource list on 5 topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources
8b. Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.	**PCMH 5: Track and Coordinate Care,** **Element B: Referral Tracking and Follow-up (MUST PASS)** *The practice:* 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals 9. Documents co-management arrangements in the patient's medical record 10. Asks patents/families about self-referrals and requesting reports from clinicians

	Change Concept Element	2014 NCQA PCMH Standards
CARE COORDINATION	8c. Track and support patients when they obtain services outside the practice.	**PCMH 2: Team-Based Care,** **Element B:** *The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:* 1. The practice is responsible for coordinating patient care across multiple settings 3. The practice functions most effectively as medical home if patients provide a complete medical history and information about care obtained outside the practice 8. Instructions on transferring records to the practice, including a point of contact at the practice **PCMH 5: Track and Coordinate Care,** **Element B: Referral Tracking and Follow-up (MUST PASS)** *The practice:* 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50% of referrals 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports 9. Documents co-management arrangements in the patient's medical record 10. Asks patents/families about self-referrals and requesting reports from clinicians

	Change Concept Element	2014 NCQA PCMH Standards
CARE COORDINATION	8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.	**PCMH 5: Care Coordination and Care Transitions,** **Element C: Coordinate Care Transitions** *The practice:* 1. Proactively identifies patients with unplanned hospital admissions and ED visits 2. Shares clinical information with admitting hospitals and ED's 3. Consistently obtains patient discharge summaries from the hospital and other facilities 4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit 5. Exchanges patient information with the hospital during a patient's hospitalization 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50% of patient transitions of care
	8e. Communicate test results and care plans to patients/ families.	**PCMH 1: Patient-Centered Access,** **Element C: Electronic Access** *The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system.* 1. More than 50 percent of patients have online access to heir health information within four business days of when the information is available to the practice 2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party 3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits

	Change Concept Element	2014 NCQA PCMH Standards
CARE COORDINATION	8e. Communicate test results and care plans to patients/families.	**PCMH 2: Team-Based Care,** **Element A: Continuity** *The practice provides continuity of care for patients/families by:* 4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care **PCMH 4: Care Management and Support,** **Element B: Care Planning and Self-Care Support** *The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of patients identified in* **Element A:** 5. Is provided in writing to the patient/family/caregiver **PCMH 5: Care Coordination and Care Transitions,** **Element A: Test Tracking and Follow-up** *The practice has a documented process for and demonstrates that it:* 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults) 7. More than 30% of laboratory orders are electronically recorded in the patient record 8. More than 30% of radiology orders are electronically recorded in the patient record 9. Electronically incorporates more than 55% of all clinical lab test results into structured fields in medical record 10. More than 10% of scans and tests that result in an image are accessible electronically

Safety Net Medical Home Initiative

The goal of the Safety Net Medical Home Initiative (2008-2013) was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh), representing 65 safety net practices across the U.S. The partner sites and Regional Coordinating Centers that participated in the SNMHI were members of a learning community working toward the shared goal of PCMH transformation. The *SNMHI Implementation Guide Series* was informed by their work and knowledge, and that of many organizations that partnered to support their efforts.

The SNMHI was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The Initiative also received support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center.

For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

For more information about The Commonwealth Fund, refer to www.cmwf.org.