Town Hall Meeting for CCEs

What does NCQA PCMH Redesign and PCMH 2017 Mean for PCMH CCEs?

Monday, February 27, 2017 | Webinar
11:30 a.m. - 1:00 p.m. ET
Telephone Numbers

Customer Support 888-275-7585

- General Information
- Educational Seminar Registration
- Publications Center

NCQA Web Site
www.ncqa.org

Policy Clarification Support
https://my.ncqa.org/

PCMH CEC
http://www.ncqa.org/cec
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Town Hall Information
Town Hall Meeting for CCEs:
What does NCQA PCMH Redesign and PCMH 2017 Mean for PCMH CCEs?

PCMH CCEs are valued ambassadors of the Patient-Centered Medical Home. As we transition from PMCH 2014 to PCMH 2014, we invite CCEs to join us for a special session with members of the NCQA Leadership Team and key staff who have helped to develop this new product.

During this meeting, we will highlight new components of the program, explain documentation requirements, and the annual check-ins process. We will preview areas of the new platform and discuss the vital role CCEs will play in assisting practices.

NCQA is committed to innovation and helping you support your clients.

Agenda

Welcome
Shauna R. Brown, MSL, PCMH CCE

Current Landscape for CCEs
Shauna R. Brown, MSL, PCMH CCE

PCMH Redesign Overview
Michael S. Barr, MD, MBA, MACP

PCMH 2017 Preview
Tricia Barrett, MSHA, PCMH CCE

Open Discussion/Question and Answer Session

Closing Remarks

Objectives

At the conclusion of this educational activity, participants will be able to:

- Describe the new components of the PCMH 2017 program.
- Review the Q-PASS submission platform and annual check-in process.
- Discuss the importance of the role of a PCMH CCE in assisting practices in committing, transforming, and sustaining the recognition.
Continuing Education

As PCMH CCE, this town hall provides maintenance of certification credit of 2.0 points under ‘required continuing education.’ This complimentary training can be used in lieu of one of the Quarterly Webinars for CCEs.

This is a non CME/CNE/CPE activity.

Leadership Team Hosts

Michael S. Barr, MD, MBA, MACP
Executive Vice President, Quality Measurement & Research Group

Michael S. Barr is a board-certified internist and executive vice president for the Quality Measurement & Research Group at NCQA. His portfolio at NCQA includes performance measurement development; research; managing NCQA’s contracts and grants portfolio; and contributing to strategic initiatives, public policy and educational programs. Prior to joining NCQA in 2014, Barr was senior vice president, Division of Medical Practice for the American College of Physicians, where he was responsible for promoting patient-centered care through development of programs, services and quality improvement initiatives for internists and other health care professionals.

From 1999–2005, Barr was chief medical officer for Baltimore Medical System, Inc., a Joint Commission accredited Federally-Qualified Health Center. He practiced internal medicine full time in the Division of General Internal Medicine at Vanderbilt University from 1993–1998 and held various administrative positions, including physician director, Medical Management Programs, for the Vanderbilt Medical Group. From 1989–1993, Barr was an active duty physician in the United States Air Force at Moody Air Force Base, Georgia.

Barr has a BS in forest biology from the State University of New York, College of Environmental Science and Forestry. He attended New York University School of Medicine through the U.S. Air Force Health Professions Scholarship Program, completed his residency in internal medicine at Rush-Presbyterian-St. Luke’s Medical Center in Chicago and earned an MBA from the Vanderbilt Owen Graduate School of Management.

Barr was a commissioner on the Maryland Health Care Commission (2013–2015), previously served on the Health Information Technology Policy Committee Meaningful Use Workgroup (2010–2012) and is currently on the Board of Trustees of The Horizon Foundation of Howard County.
Tricia Marine Barrett joined NCQA in 2008 as vice president for Product Design & Support. She is responsible for exploring new product concepts and evolving existing products to meet the needs of a changing health care environment. She also ensures proper development, communication and interpretation of NCQA Accreditation standards, HEDIS measures and Clinician Recognition programs.

Prior to joining NCQA, Barrett was lead consultant on managed care for General Motors. As HAP associate vice president and the program director for the HAP/GM Managed Care Consulting Team, she was responsible for evaluating the quality and efficiency of GM’s managed care offerings nationally and for establishing supplier development activities with all of GM’s HMOs. In this role, she participated on the NCQA Purchaser Advisory Council, the National Business Coalition on Health eValue8 Steering Committee and served as an author and scorer for the eValue8 RFI.

Barrett worked for 14 years at the Health Alliance Plan (HAP) in Detroit, where she served in a variety of roles, including manager of Research, Analysis and Program Development; acting director of Managed Care Information; and director of Quality Management. As QM director, she was responsible for all clinical quality improvement and disease management programs, as well as HEDIS production and NCQA Accreditation for the organization as a whole. Barrett was also a member of the NCQA HEDIS Policy Panel and chairperson for the Measurement Committee of the Michigan Quality Improvement Consortium (MQIC).

Barrett received a bachelor’s degree in sociology from the University of Michigan and a master’s degree in health services administration from the School of Public Health.
Slide Presentation
Town Hall Meeting for CCEs

What does NCQA PCMH Redesign and PCMH 2017 Mean for PCMH CCEs?

NCQA Leadership Team
February 27, 2017

Agenda

CURRENT LANDSCAPE FOR CCES
PCMH REDESIGN
PCMH 2017
TRANSITIONS
FUTURE CHANGES
Q&A
Hosted Today By

Michael S. Barr, MD, MBA, MACP
Executive Vice President
Quality Measurement & Research Group

Tricia Barrett, MSHA, PCMH CCE
Vice President
Product Design and Support

Current Landscape
Current Landscape

- **Rewarding Value**
- **Improving Quality**
- **Move towards PCMHC and Better Integration**

Patient-Centered Care

*Overview*

Diagram showing various components of patient-centered care, including urgent care, behavioral health, other providers, school-based clinics, on-site clinics, retail clinics, and specialists.
Patient-Centered Care

Benefits

62%

of total lower spending per NCQA PCMH Medicare beneficiary was attributable to reductions in payments to acute care hospitals

$265

Lower average annual total Medicare spend per beneficiary for patients in NCQA recognized practices


Patient-Centered Care

Benefits

Lower risk-adjusted ED use and hospitalizations for adult patients treated within NCQA recognized PCMH.

11%

Lower risk-adjusted use of ED services

12%

Fewer hospitalizations

15%

Lower PMPM costs for patients in a PCMH

PCMH Redesign

Now vs. Future

**Now**
- Self-guide to recognition
- Submit documents all at once
- Cumbersome survey tool
- Recognition is a 3-year cycle, has 3 levels

**Soon**
- NCQA representative to guide you
- Gradual submissions, steady feedback
- More intuitive tool, with user tips
- Yearly reporting, more frequent help, no levels
Introducing Q-PASS
Replacing two disconnected systems with one user-friendly sign on

PCMH Redesign
3 Parts

Commit
Practice completes an online guided assessment.
Practice works with an NCQA representative to develop an evaluation schedule.
Practice works with NCQA representative to identify support and education for transformation.
New NCQA PCMH online education resources support the transformation process.

Transform
Practice submits initial documentation and checks in with its evaluator.
Practice submits additional documentation and checks in with its evaluator.
Practice submits final documentation to complete submission and begin NCQA evaluation process.
Practice earns NCQA Recognition.

Succeed
Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).
Practice demonstrates continued readiness and high quality performance through annual reporting to NCQA.
PCMH Redesign

Commit

- Practice completes an online guided assessment.
- Practice works with an NCQA representative to develop an evaluation schedule.
- Practice works with NCQA representative to identify support and education for transformation.
- New NCQA PCMH online education resources support the transformation process.

CCE Opportunities

- Assist practices in determining if they are prepared to enroll and begin transforming.
- Assist practices in determining their pace and establish a workplan.
- Consults with practices to determine gaps in skills, address team structure and organization, leadership and cultural issues.
- Consults with practice to identify NCQA and other education resources and materials to train staff and adopt new workflows.

PCMH Redesign

Each practice will have a Dashboard to manage their work.
NCQA’s Redesigned System - Q-PASS

Roles in Q-PASS allow CCEs access to work with their clients

### Concept:
The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, organizes and trains staff to work to the top of their license and provide effective team-based care.

### TC: Team-Based Care and Practice Organization

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<thead>
<tr>
<th>TC</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>TC 01</td>
<td>PCMH Transformation Leads (Core)</td>
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<td>TC 02</td>
<td>Structure &amp; Staff Responsibilities (Core)</td>
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<td>TC 03</td>
<td>External PCMH Collaborations (1 Credit)</td>
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<td>TC 04</td>
<td>Patient/Family/Caregiver Involvement in Governance (2 Credits)</td>
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<td>TC 05</td>
<td>Certified EHR System (2 Credits)</td>
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<td>TC 06</td>
<td>Individual Patient Care Meetings/Communication (Core)</td>
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<td>TC 07</td>
<td>Staff Involvement in Quality Improvement (Core)</td>
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<td>TC 08</td>
<td>Behavioral Health Care Manager (2 Credits)</td>
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<tr>
<td>TC 09</td>
<td>Medical Home Information (Core)</td>
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</tbody>
</table>

### Transform

**Commit**
- Practice completes an online guided assessment.
- Practice works with an NCQA representative to develop an evaluation schedule.
- Practice works with NCQA representative to identify support and education for transformation.
- New NCQA PCMH online education resources support the transformation process.

**Transform**
- Practice submits initial documentation and checks in with its evaluator.
- Practice submits additional documentation and checks in with its evaluator.
- Practice submits final documentation to complete submission and begin NCQA evaluation process.
- Practice earns NCQA Recognition.

### CCE Opportunities

- Consults with practices to identify what evidence will be prepared in advance and what will be demonstrated.
- Participates in the virtual check ins to assist the practice in their evaluation.
- Consults with practices post check ins to plan next steps in the workplan.
- Participates in final check in to achieve and celebrate recognition.
Q-PASS Supports Transformation

Concepts are presented to encourage education and flexibility

NCQA’s Redesigned System - Q-PASS

Practices and CCEs can pursue various pathways depending on their plan
**PCMH Redesign**

**Succeed**

**Commit**
Practice completes an online guided assessment.

- Practice works with an NCQA representative to develop an evaluation schedule.
- Practice works with NCQA representative to identify support and education for transformation.
- New NCQA PCMH online education resources support the transformation process.

**Transform**
Practice submits initial documentation and checks in with its evaluator.

- Practice submits additional documentation and checks in with its evaluator.
- Practice submits final documentation to complete submission and begin NCQA evaluation process.
- Practice earns NCQA Recognition.

**Succeed**
Practice is prepared for new payment environment (value-based payment, MACRA MIPS/APMs).

- Practice demonstrates continued readiness and high quality performance through annual reporting to NCQA.

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**NCQA’s Redesigned System - Q-PASS**

*Manage Evaluations for Check-Ins and Annual Reporting*
Sustaining Recognition

Engage practices in an annual check-in providing confirmation of continuing commitment and performance.

Each practice demonstrates that changes made during the initial recognition effort are part of their culture, and practice is becoming more patient-centered.

CCEs continue to support practice preparation for their annual reporting each year and ongoing quality improvement.

PCMH 2017 Standards
Evolution of the PCMH Standards
Continue to Move Practices Closer to Achieving the Triple Aim

2011
- Emphasizes relationship with/expectations of specialists
- Integrates behaviors affecting health, language, CLAS
- Enhances evaluation of patient experience
- Underscores importance of system cost-savings
- Enhances use of clinical performance measure results

2014
- Further incorporates behavioral health
- Additional emphasis on team-based care
- Focusses on care management of high need populations
- Higher bar, alignment of QI activities with "triple aim"

2017
- Addition of Annual reporting requirements
- Further integrates social determinants & community connections
- Shift from focus on structure to focus on outcomes
- Further integrates behavioral health

2017 Standards

Structure

Concepts, Competencies and Criteria
Replaces the model of Standards, Elements and Factors

- Concepts: Over-arching components of PCMH
- Competencies: Ways to think about/bucket criteria
- Criteria: The individual things/tasks you do to make up a PCMH
2017 Standards

Concepts

Team-Based Care and Practice Organization

Knowing and Managing Your Patients

Patient-Centered Access and Continuity

Care Management and Support

Care Coordination and Care Transitions

Performance Measurement & Quality Improvement

Highlights of Changes to PCMH

Improve focus and flexibility

- Reduced total criteria to 100 from 167 factors in 2014
- Core/elective approach allows practices to tailor program to their population
- Eliminated structure in favor of ‘outcome’

Support continuous practice transformation

- Includes activities necessary to achieve stated aims and drive improvement
- Focuses on whether the intent was achieved and care was improved

Update documentation methods

- Accommodates a spectrum of practices (basic-complex, small-large)
- Allows a variety of response options that demonstrate a requirement is met
- Introduces virtual review

Emphasize comprehensive, integrated care

- Understanding behavioral needs and social determinants included in core
- Deeper integration and community connections included in electives
2017 Standards
Changes

2017 Distinction Modules
Practice Opportunities to Show Excellence

Distinction in Patient Experience Reporting
Distinction in Behavioral Health Integration
Distinction in Electronic Measure Reporting
## 2017 Standards

**Concepts**

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<thead>
<tr>
<th>Team-Based Care and Practice Organization</th>
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<tr>
<td>Practice leadership</td>
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<tr>
<td>Care team responsibilities</td>
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<tr>
<td>Orientation of patient/families/car egivers</td>
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<table>
<thead>
<tr>
<th>Knowing and Managing Your Patients</th>
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<tr>
<td>Data collection</td>
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<tr>
<td>Medication reconciliation</td>
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<td>Evidence-based clinical decision support</td>
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<td>Connection with community resources</td>
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<tr>
<th>Patient-Centered Access and Continuity</th>
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<tr>
<td>Access to practice and clinical advice</td>
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<tr>
<td>Care continuity</td>
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<td>Empanelment</td>
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## 2017 Standards

**Concepts**

<table>
<thead>
<tr>
<th>Care Management and Support</th>
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<tr>
<td>Identifying patients for care management</td>
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<tr>
<td>Person-centered care plan development</td>
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<th>Care Coordination and Care Transitions</th>
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<tr>
<td>Management of lab/imaging results</td>
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<td>Tracking and managing patient referrals</td>
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<td>Care transitions</td>
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<tr>
<th>Performance Measurement &amp; Quality Improvement</th>
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<tr>
<td>Collecting and analyzing performance data</td>
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<td>Setting goals</td>
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<tr>
<td>Improving practice performance</td>
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<tr>
<td>Sharing practice performance data</td>
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</tbody>
</table>
2017 Standards

**Scoring**

Core Criteria

Elective Criteria

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2017 Standards

**Structure - Example**

**Concept**: A brief title describing the criteria; uses a two-letter abbreviation (XX).

**Competency**: A brief description of criteria subgroup, organized within the broader concept.

**Criteria**: A brief statement highlighting PCMH requirements.

**TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)**

Intent: 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 provide effective team-based care.

**Competency A**: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

**TC1 * Core**

Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.
NCQA’s Redesigned System - Q-PASS

Practices can select and link documents and present examples virtually

**DESCRIPTION**

The practice demonstrates that it informs patients, families and caregivers about the role of the medical home and provides materials containing that information.

**SUGGESTED EVIDENCE**

MHIM: Medical Home Information & Materials (for reporting year)

The practice demonstrates that it informs patients, families and caregivers about the role of the medical home and provides materials containing that information.

**ACTIONS**

- We need help
- This is not applicable to us
- Ready for check in

We have different evidence

Let’s do a virtual review
COMPETENCY A: Commitment, Organization and the Care Team

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.

### Criteria

<table>
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<th>Type</th>
<th>Guidance</th>
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<tr>
<td>TC1</td>
<td>Designates a clinician lead for the medical home and staff person to manage the PCMH transformation and medical home activities.</td>
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</tbody>
</table>

- **Core:** PCMH transformation is successful when there is support from the clinician lead at the practice. The clinician lead is key to ensuring the success of the transition and how the practice will function as a medical home. The clinician lead and PCMH transformation manager may be the same person or in some cases, it is beneficial to have the clinician lead set the tone for the entire practice and to acknowledge the role of other staff in the everyday operations.

- **Information about clinician lead:**
  - Include name, credentials, description of clinician lead at the practice.

- **Information about PCMH manager:**
  - Include name, credentials, description of PCMH manager at the practice.

---

**Responding to Feedback**

*With Educational Resources*
**2017 Standards**  
*In Review*

- Improves focus and flexibility
- Supports continuous practice transformation
- Updates documentation methods
- Emphasizes comprehensive, integrated care

**Getting to Sustaining Recognition**  
*Transition Options for Currently Recognized Practices*

Videos, instructions and decision trees are at this link:  
http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh pcmh-redesign
NCQA Medical Neighborhood Recognitions
Closing the Loop Between PCPs, Specialists & Other Sites of Care

As of January 19, 2017

Moving Forward…
Let's Continue to Grow the Patient-Centered Medical Neighborhood!

2017+

PCMH 2017 and Q-PASS launch April 3rd

Bringing PCSP and other recognition programs into new process (2018+)

Moving forward with NCQA eMeasure Certification of vendors and evolving Distinction for Electronic Measure Reporting for practices
Data connections for quality measures

Medical Neighborhood Programs Align with Medical Board Certification Requirements

American Board of Pediatrics
PCMH & PCSP
40 MOC points
(Part IV)

American Board of Family Medicine
(PCMH only)
40 MOC points
(Performance Improvement)

American Board of Internal Medicine
PCMH & PCSP
40 MOC points
(Practice Assessment)
+ Meets Patient Safety Requirement
NCQA PCMH Aligns with State and Federal Initiatives

HRSA Patient-Centered Medical Home Initiative
Community Health Centers – for rural, underserved, often nurse-led practices
Recognition costs and technical assistance
Up to 500 Community Health Centers per year; 5 year contract

1,675 sites currently enrolled
1,657 CHCs Recognized

MACRA CMS’s Quality Payment Program

MERIT-BASED INCENTIVE PERFORMANCE SYSTEM
FFS + performance bonuses/penalties for:
1. Quality,
2. Resource Use,
3. Clinical Practice Improvement
4. Advancing Care Information

ALTERNATIVE PAYMENT MODELS
Automatic 5% bonus for either
• 2-sided risk, performance-based pay, use of Certified EHRs & revenue/patient thresholds
• OR expanded CMMI demonstrations

2017 Performance determines 2019 pay

2019 2020 2021 2022 Onward

CPS Threshold

MIPS*
The PCMH/PCSP value proposition

NCQA PCMH & PCSP IA auto-credit

Largest PCMH program to qualify
No other PCSP programs qualify
Others must be national programs or state/commercial programs with at least 500 practices meeting specific criteria

100% automatic credit for IA

PCMH/PCSPs within non-qualified APMs bring auto credit and boost overall scores

PCMHs/PCSPs also should have:
- Higher quality scores
- Lower resource use
- Higher ACI scores

PCMH/PCSP are solid foundations for APMs

2017 Standards

Where to get information

Practices and CCEs with questions can contact NCQA at my.ncqa.org.

PCMH 2017 Training:

- Introduction to PCMH 2017: Foundational Concepts of the Medical Home
  May 16-17 | Baltimore, MD
- Advanced PCMH 2017: Succeeding in Medical Home Recognition
  May 18 | Baltimore, MD
- Introduction to PCMH 2017: Foundational Concepts of the Medical Home
  July 25-26 | Los Angeles, CA
- Advanced PCMH 2017: Succeeding in Medical Home Recognition
  July 27 | Los Angeles, CA
- Introduction to PCMH 2017: Foundational Concepts of the Medical Home
  October 17-18 | Fort Lauderdale, FL
- Advanced PCMH 2017: Succeeding in Medical Home Recognition
  October 19 | Ft. Lauderdale, FL
CCEs will need to attend an Introduction to PCMH 2017 course or one of the following by January 31, 2018:

Transitioning from PCMH 2014 to PCMH 2017: Commit, Transform, Succeed (live)
- November 2, 2017 (Orlando, FL)
- Register here: [http://pmchcongress.com/content/rates-and-dates](http://pmchcongress.com/content/rates-and-dates)

Transitioning from PCMH 2014 to PCMH 2017: Commit, Transform, Succeed (online module)
- TBA—Summer 2017

Also note:
Resource directory of public and private initiatives:
[NCQA Incentives Directory](http://pmchcongress.com/content/rates-and-dates)
Request to join CCE MNCOP Group in LinkedIn:
[https://www.linkedin.com/groups/Medical-Neighborhood-Community-Practice-8540934/about](https://www.linkedin.com/groups/Medical-Neighborhood-Community-Practice-8540934/about)
Thank you
PCMH CCE Resources
2017 Standards Preview:

Patient-Centered Medical Home Recognition

Click Link:
Quality Measures
Crosswalk for PCMH 2017
## Quality Measures Crosswalk for PCMH 2017

Reference Guide Produced by NCQA

<table>
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<tr>
<th>Measure Title</th>
<th>NQF # (CMS eCQM #)</th>
<th>Population</th>
<th>NCQA eMeasure Certification</th>
<th>CMS/AHIP Consensus Core Set ACO &amp; PCMH</th>
<th>CPC+</th>
<th>HEDIS Plan Level &amp; Medicare Star Rating System</th>
<th>NCQA PCMH Recognition</th>
<th>Owner (Developer)</th>
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<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder Medication</td>
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<td>Coronary Artery Disease: Beta-Blocker Therapy—Prior Myocardial Infarction or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
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</tr>
<tr>
<td>Diabetes: Medical Attention for Nephropathy</td>
<td>62 (134)</td>
<td>Adult</td>
<td>✓</td>
<td>✓</td>
<td>✓‡</td>
<td></td>
<td></td>
<td>NCQA</td>
</tr>
<tr>
<td>Functional Status Assessments for Congestive Heart Failure</td>
<td>NA (90)</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMS (NCQA)4</td>
</tr>
<tr>
<td>Measure Title</td>
<td>NQF # (CMS eCQM #)</td>
<td>Population</td>
<td>NCQA eMeasure Certification</td>
<td>CMS/AHIP Consensus Core Set ACO &amp; PCMH</td>
<td>CPC+</td>
<td>HEDIS Plan Level &amp; Medicare Star Rating System</td>
<td>NCQA PCMH Recognition</td>
<td>Owner (Developer)</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------------</td>
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<td>----------------------------------------</td>
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<td>-----------------------------------------------</td>
<td>------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction</td>
<td>2907 (135)</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMA PCPI</td>
</tr>
<tr>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction</td>
<td>2908 (144)</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMA PCPI</td>
</tr>
<tr>
<td>Hypertension: Improvement in Blood Pressure (Intermediate Outcome)</td>
<td>NA (65)</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMS (NCQA)</td>
</tr>
<tr>
<td>Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet</td>
<td>68 (164)</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCQA</td>
</tr>
<tr>
<td>Use of High-Risk Medications in the Elderly</td>
<td>22 (156)</td>
<td>Adult</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>52 (166)</td>
<td>Adult</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>38 (117)</td>
<td>Pediatric</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>41 (147)</td>
<td>Adult/Pediatric</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>AMA PCPI</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>2372 (125)</td>
<td>Adult</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>32 (124)</td>
<td>Adult</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Chlamydia Screening for Women</td>
<td>33 (153)</td>
<td>Adult/Pediatric</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>34 (130)</td>
<td>Adult</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>NCQA</td>
</tr>
<tr>
<td>Falls: Screening for Future Fall Risk</td>
<td>101 (139)</td>
<td>Adult</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>AMA PCPI</td>
</tr>
<tr>
<td>Measure Title</td>
<td>NQF # (CMS eCQM #)</td>
<td>Population</td>
<td>NCQA eMeasure Certification</td>
<td>CMS/AHIP Consensus Core Set ACO &amp; PCMH</td>
<td>CPC+</td>
<td>HEDIS Plan Level &amp; Medicare Star Rating System</td>
<td>NCQA PCMH Recognition</td>
<td>Owner (Developer)</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------</td>
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<td>------</td>
<td>-----------------------------------------------</td>
<td>------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Maternal Depression Screening</td>
<td>NA (82)</td>
<td>Adult/Pediatric</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCQA</td>
</tr>
<tr>
<td>Pneumococcal Vaccination Status for Older Adults</td>
<td>43 (127)</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCQA</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan</td>
<td>421 (69)</td>
<td>Adult</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td>CMS (QIP)</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan</td>
<td>418 (2)</td>
<td>Adult/Pediatric</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMS (QIP)</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>28 (138)</td>
<td>Adult</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td>AMA PCPI</td>
</tr>
<tr>
<td>Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists</td>
<td>NA (74)</td>
<td>Adult/Pediatric</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMS (NCQA)</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>24 (155)</td>
<td>Pediatric</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NCQA</td>
</tr>
<tr>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>NA (50)</td>
<td>Adult/Pediatric</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td>CMS (NCQA)</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>419 (68)</td>
<td>Adult</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td>CMS (QIP)</td>
</tr>
</tbody>
</table>

NCQA intends to accept the results of these measures for the 2017 PCMH program. The specifications for these measures are available through CMS eCQM Library at: [https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html)

- Measure included in Quality Payment Program Merit-based Incentive Payment System (MIPS)
- HEDIS and Medicare Star measure specifications differ from CMS eCQM specification
- HEDIS Measure included here though HEDIS specification is different than CMS eCQM specification and data collection methodology is via Electronic Clinical Data Systems Reporting (ECDS)
- Medicare Stars measures: A version of this measure is included in the Medicare Stars program though the specifications and method of collection differ from the CMS eCQM version used for the PCMH 2017 program.
1 NCQA: NCQA is the owner and steward of these measures.
2 AMA PCPI: Copyright 2015 PCPI(R) Foundation and American Medical Association. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain.
   Commercial uses of the Measures require a license agreement between the user and the PCPI(R) Foundation (PCPI[R]) or the American Medical Association (AMA). Neither the American Medical Association (AMA), nor the AMA-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI), now known as the PCPI, nor their members shall be responsible for any use of the Measures.
3 MNCM: Copyright MN Community Measurement, 2016. All rights reserved.
4 CMS (NCQA): These measures are included with the permission of the measure owner and steward, the Centers for Medicare & Medicaid Services (CMS). CMS contracted with NCQA to develop this electronic measure.
5 CMS (QIP): These measures are included with the permission of the measure owner and steward, the Centers for Medicare & Medicaid Services (CMS). CMS contracted with Quality Insights of PA to develop this electronic measure.
Annual Reporting Requirements for PCMH Recognition:
Overview & Table
Redesign Goals

NCQA is redesigning our PCMH Recognition program. The redesigned program—to be launched April 3, 2017—includes ongoing status as a recognized practice with annual check-in and reporting, replacing the current program’s three-year recognition cycle. Our redesigned program offers:

- **Flexibility.** Practices take the path to recognition that suits their strengths, schedule and goals.
- **Personalized service.** Practices get more interaction with NCQA. Each practice is assigned a NCQA Representative who’ll serve as the primary NCQA contact and “go-to” guide.
- **User-friendly approach.** Reporting requirements remain meaningful, but with simplified reporting and less paperwork.
- **Continuous improvement.** Annual checks help practices strengthen as medical homes by frequently reviewing progress and encouraging performance improvement.
- **Alignment with changes in health care.** The program aligns with current public and private initiatives and can adapt to future changes.

Our recognition process has three parts:

1. **Commit.** When a practice signs up to work with NCQA, they complete an assessment online. The practice receives guidance from their NCQA Representative to determine their evaluation plan and schedule.

2. **Transform.** Practices gradually transform, building upon their prior success. During this time, they demonstrate progress by submitting documentation and data to be evaluated by NCQA. Practices submit through a newly streamlined system designed to reduce paperwork and administrative hassles.

   Along the way, NCQA conducts virtual reviews—check-ins—with the practice to gauge progress and to discuss next steps in the evaluation. The virtual reviews—conducted via screen sharing technology—give practices immediate and personalized feedback on what is going well and what needs to improve. This makes NCQA evaluations more educational and collaborative.

3. **Succeed.** The practice continues to implement and enhance their PCMH model to meet the needs of patients. Each year, the practice checks in with NCQA to demonstrate ongoing activities consistent with the PCMH model and the implementation of PCMH standards. This reporting includes attesting to certain policies and procedures and submission of key data.

New Online Platform

NCQA will launch a new online platform to support the new recognition process. Practices will be able to apply for recognition, sign agreements, access training and other resources, submit documentation, update and confirm data, track evaluations completed, print certificates and sustain their recognition using this system. The new platform will be released on April 3, 2017.
Sustaining Your Recognition
This document focuses on data reporting requirements for the annual check-in. Practices will demonstrate they continue to align with recognition requirements by submitting data and documentation on these critical aspects of PCMH:

- Patient-centered access.
- Team-based care.
- Population health management.
- Care management.

Practices will also have the opportunity to submit data and documentation on special topics, such as behavioral health.

Annual Check-In Process: Data Reporting, Audit and Decision
- Practices will use the new online platform for submission of documentation that supports reporting requirements at their annual check-in.
- Practices must complete a self-assessment at the annual check-in, verifying core features of the medical home have been sustained.
- Practices must meet the minimum number of requirements for each category.
- NCQA reviews submission and notifies practices of their sustained recognition status.
- NCQA will randomly select practices for audit to validate attestation and submitted documentation and data.
- Practices that do not submit data on time or fail to meet other requirements may have their recognition status suspended or revoked.

Annual Check-in Requirements (Annual Assessment and Reporting Requirements)
Practices will attest to core criteria based on the current PCMH program, which consists of key expectations that recognized practices must meet as a medical home. In addition, the PCMH Annual Reporting Requirements table (starting on page 3 of this document) outlines reporting options for eligible recognized practices through successfully transformation and achievement of PCMH 2014 Level 3 recognition.

Annual reporting requirements may be removed, modified or added over time. Practices will be notified of changes and given time to prepare data and documentation.

Reporting Measures to NCQA?
NCQA has identified measures acceptable for annual reporting and will update this list periodically. The list of measures from which to choose can be found here.

Electronic Clinical Quality Measures
Electronic Clinical Quality Measures (eCQMs) are standardized performance measures from electronic health records (EHR) or health information technology systems. Beginning with launch of the PCMH 2017 program, practices will have the option to submit electronic clinical quality measures (eCQMs) to NCQA in support of their recognition process. The identified measures can be submitted through electronic health records, health information exchanges, qualified clinical data registries (QCDRs) and data analytics companies as long as they can use the electronic specifications as defined by the Centers for Medicare & Medicaid Services for the ambulatory quality reporting programs. More details about the submission process to NCQA will be forthcoming.
Patient-Centered Access

Has your practice continued to monitor appointment access?

*Choose 1 option from the 3 below to submit for your annual check-in.*

<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Data/Documentation Required</th>
</tr>
</thead>
</table>
| **1**    | Monitor appointment access on patient experience survey | If your patient experience survey includes questions related to access, provide the following:  
1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD)  
2. Number of patients surveyed in the past 12 months. (Data, SS)  
3. Number of completed surveys in the past 12 months. (Data, SS)  
4. A report with results from the access questions. (Documentation; CD, if report is stratified by site.) |
| **2**    | Provide third next available appointment |  
1. Provide the third next available appointment for urgent appointments. (Data, SS)  
2. Provide the third next available appointment for routine appointments (new patient physical, routine exam, return visit exam). For routine requests, exclude any appointments blocked for same-day or urgent visits (since they are “blocked off” the schedule). (Data, SS)  

Practices may use the Institute for Healthcare Improvement’s (IHI) method to calculate the third next available appointment.  
- Sample all clinicians on the team once a week, on the same day, at the same time of day, *for at least one month* between annual check-ins.  
- Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam.  
- Report the average number of days for all physicians sampled.  

*Note:* Count calendar days (e.g. include weekends) and days off.
<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Data/Documentation Required</th>
</tr>
</thead>
</table>
| 3        | Demonstrate other method of monitoring access for urgent and routine appointments | 1. Demonstrate a method used for enhanced patient scheduling/same-day service. (Documentation, SS)  
Examples may include:  
- A report showing monitoring of access to both urgent and routine (new patient physical, routine exam, return visit exam) appointments using a method other than option 2. The method must exclude use of appointment times from cancellations and no-shows and demonstrate a minimum of 5 consecutive days.  
- A summary or report of appointments designated for same-day urgent and routine visits.  
**Note:** Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement. Conducting a walk-in clinic does not meet the requirement. There should be appointments available to allow for patient planning needs. |
Team-Based Care

Has your practice continued to use a team-based approach to provide primary care?
*Choose 1 option from the 2 below to submit for your annual check-in.*

<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Data/Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CD= Corporate Data Accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SS = Site-Specific Data Required</td>
</tr>
</tbody>
</table>

### Option 1: Attest to pre-visit planning activities

1. Does your practice anticipate and plan for upcoming visits? Check any of the following formats that your practice uses. (CD)
   - ☐ Team meetings/huddles.
   - ☐ Structured communication.
   - ☐ Dashboard in the EHR.
   - ☐ Checklist.
   - ☐ Appointment notes.
   - ☐ Other ____________________

### Option 2: Measure team-based care in your employee experience/satisfaction survey (e.g., collaboration, communication, team dynamics)

If your employee experience/satisfaction survey covers, at a minimum, collaboration, communication and team dynamics, provide the following:

1. Copy of the employee experience survey tool. (Documentation, CD)
2. Number of employees (staff/clinicians) surveyed in the past 12 months. (Data; CD, at least 1 employee from each site must be included)
3. Number of employees (staff/clinicians) who completed the survey in the past 12 months. (Data; CD, at least 1 employee from each site must be included)
4. Report of results for all questions related to collaboration, communication, team dynamics. (Documentation; CD, report does not need to be stratified by site)
Population Health Management

Has your practice continued to proactively remind patients of upcoming services?

*Submit the information requested for your annual check-in.*

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required</strong></td>
<td>CD= Corporate Data Accepted</td>
</tr>
<tr>
<td>Provide reminders for at least 5 different services across at least 2 categories below:</td>
<td>SS = Site-Specific Data Required</td>
</tr>
<tr>
<td>• Preventive care services.</td>
<td></td>
</tr>
<tr>
<td>• Immunizations.</td>
<td></td>
</tr>
<tr>
<td>• Chronic or acute care services.</td>
<td></td>
</tr>
<tr>
<td>• Patients not seen regularly.</td>
<td></td>
</tr>
<tr>
<td>• Patients who need medication monitoring or alerts.</td>
<td></td>
</tr>
</tbody>
</table>

For each reminder:

1. Identify the service for which patients received a reminder. (CD)
   - Preventive care services.
   - Immunizations.
   - Chronic or acute care services.
   - Patients not seen regularly.
   - Patients who need medication monitoring or alerts.

2. Provide frequency of identification of patients/sending reminders to patients (monthly, quarterly, annually, other). (CD)

*Note: If 75 percent of clinicians have DRP or HSRP recognition, practice receives credit for three chronic care services.*
Has your practice continued to identify patients who may benefit from care management?

Submit the information requested for your annual check-in.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items 1 and 2 are required; items 3-5 are optional.</td>
<td>CD= Corporate Data Accepted</td>
</tr>
<tr>
<td>Identify patients who may benefit from care management</td>
<td>SS = Site-Specific Data Required</td>
</tr>
<tr>
<td>1. The practice selects which of the following are considered in their criteria for identifying patients who may benefit from care management. Practices must use at least two from the list below. (CD)</td>
<td></td>
</tr>
<tr>
<td>• Behavioral health conditions.</td>
<td></td>
</tr>
<tr>
<td>• High cost/high utilization.</td>
<td></td>
</tr>
<tr>
<td>• Poorly controlled or complex conditions.</td>
<td></td>
</tr>
<tr>
<td>• Social determinants of health.</td>
<td></td>
</tr>
<tr>
<td>• Referrals by outside organizations, practice staff or patient/family/caregiver.</td>
<td></td>
</tr>
<tr>
<td>2. The number of patients who were identified for care management using the criteria selected above. (Data, SS)</td>
<td></td>
</tr>
<tr>
<td>3. The total number of patients in the practice. (Optional data, SS)</td>
<td></td>
</tr>
<tr>
<td>4. The number of patients who have had an encounter with the practice in the past year. (Optional data, SS)</td>
<td></td>
</tr>
<tr>
<td>5. The number of patients identified for care management who have had an encounter with the practice in the past year. (Optional data, SS)</td>
<td></td>
</tr>
</tbody>
</table>
**Care Coordination and Care Transitions**

Has your practice continued to coordinate care with labs, specialists, institutional settings or other care facilities?

*Choose 1 option from the 4 below to submit for your annual check-in. You must also respond to the attestation questions.*

<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Documentation/Data Required</th>
<th>Manual Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Attest to test and referral tracking activities</td>
<td>CD= Corporate Data Accepted, SS = Site-Specific Data Required</td>
<td>No alternative reporting method available.</td>
</tr>
</tbody>
</table>

1. Does your practice use a continuous process for the following? Check any that apply:
   - Tracking labs.
   - Tracking imaging tests.
   - Transitions of care.

2. Do you track labs until results are available, flagging and following up on overdue results?

3. Do you track imaging tests until results are available, flagging and following up on overdue results?

4. Do you track referrals until specialist reports are available, flagging and following up on overdue reports? (Tracking, flagging and following up on referrals is a required factor to achieve and sustain PCMH recognition.)

---

**Referral Tracking and Follow-Up**

1. **Track percentage of referrals with a final report**

   The practice provides:
   1. **Denominator:** The number of referral orders sent to specialists. (Data, SS)
   2. **Numerator:** The number of consultant reports received from specialists from the referral order list above (count one report per referral). (Data, SS)
   3. **Reporting period:** The number of months of data provided (3–12 months). (Data, SS)

   **IF USING MANUAL DATA**
   1. **Denominator:** 30
      How to select the referral request to specialists. Pick 30 consecutive referral orders to specialists from the past year (within 12 months prior to the reporting date). (Data, SS)
   2. **Numerator:** Number of consultant reports received back from orders. Search the chart or tracking tool for the 30 referrals and report how many have a consultant report that came back to the practice from
<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Documentation/Data Required</th>
<th>Manual Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CD= Corporate Data Accepted</td>
<td>the referral (one report per order). (Data, SS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SS = Site-Specific Data Required</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Measure care coordination in patient experience survey</td>
<td>If your patient experience survey includes questions related to care coordination, provide the following: 1. Copy of the patient experience survey tool. Practices that use a CAHPS survey do not need to provide the survey. (Documentation, CD) 2. Number of patients surveyed in the past 12 months. (Data, SS) 3. Number of completed surveys in the past 12 months. (Data, SS) 4. A report with results from the care coordination questions. (Documentation, CD, if report is stratified.)</td>
<td>No alternative reporting method available.</td>
</tr>
</tbody>
</table>

### Test Tracking and Follow-Up

<p>| 3 | Track lab and imaging tests until results are available | The practice provides (separately for lab and imaging orders/results): <strong>Labs</strong> 1. Denominator: The number of lab orders sent in the prior 12 months. (Data, SS) 2. Numerator: The number of reports received from lab orders (count one report per order, with full results, even if reports for individual portions of an order come back at different times). (Data, SS) 3. Reporting period: The number of months of data provided (3–12 months). (Data, SS) <strong>Imaging</strong> 1. Denominator: The number of imaging orders sent in the prior 12 months. (Data, SS) 2. Numerator: The number of reports received from imaging orders (count one report per order, with full results, even if reports for | IF USING MANUAL DATA (30 each for lab orders and imaging orders) 1. Denominator: 30 each for lab and imaging orders (separate the lab orders from the imaging orders). Pick 30 consecutive lab orders and 30 consecutive imaging orders from the past year (within 12 months prior to the reporting date). (Data, SS) 2. Numerator: Number of lab reports received back from orders. Search the chart or tracking tool for the 30 lab orders and report how many had a lab report that came back to the practice from the lab order (one report per order, full results of all tests). (Data, SS) 3. Numerator: Number of imaging reports received back from orders. Search the chart or tracking tool for the 30 imaging orders and report how many have an |</p>
<table>
<thead>
<tr>
<th>Option #</th>
<th>Requirements</th>
<th>Documentation/Data Required</th>
<th>Manual Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CD= Corporate Data Accepted</td>
<td>imaging report that came back to the practice from the imaging order (one report per order, full results of all tests). (Data, SS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SS = Site-Specific Data Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>individual portions of an order come back at different times). (Data, SS)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td><em>Reporting period</em>: The number of months of data provided (3–12 months). (Data, SS)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4</strong> Measure percentage of care transitions for which a summary of care document or discharge instructions have been received</td>
</tr>
<tr>
<td>1. <em>Denominator</em>: The number of patient transitions identified by the practice (transitioned by a facility, including hospitals, ERs, skilled nursing facilities and surgical centers) within the prior 12-month period. (Data, SS)</td>
</tr>
<tr>
<td><strong>Note</strong>: Facilities other than hospitalizations and ED visits may be excluded.</td>
</tr>
<tr>
<td>2. <em>Numerator</em>: The number of transitions in the denominator for which practice received discharge instructions or a summary of care document, including the following data, as applicable: transitioning provider contact information, procedures, encounter diagnosis, laboratory tests, vital signs, care plan goals and instructions, discharge instructions. (Data, SS)</td>
</tr>
<tr>
<td>3. <em>Reporting period</em>: The number of months of data provided (3–12 months). (Data, SS)</td>
</tr>
<tr>
<td><strong>Note</strong>: This information is not required to be transmitted electronically.</td>
</tr>
<tr>
<td><strong>IF USING MANUAL DATA</strong></td>
</tr>
<tr>
<td>1. <em>Denominator</em>: 30 How to select care transitions. Pick 30 consecutive care transitions from the past year (within 12 months prior to the reporting date). (Data, SS)</td>
</tr>
<tr>
<td>2. <em>Numerator</em>: Number of summary care documents/discharge instructions. Search the chart or tracking tool for the 30 care transitions and report how many have discharge instructions or a summary of care document associated with them. (Data, SS)</td>
</tr>
</tbody>
</table>
# Performance Measurement and Quality Improvement

Has your practice continued to collect and use performance measurement data for quality improvement activities?

*Practices must submit the information requested for your annual check-in.*

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required</strong></td>
<td>Data/Drop-down boxes or supported by prevalidation</td>
</tr>
<tr>
<td>Measure performance</td>
<td>At least annually, the practice measures or receives data on:</td>
</tr>
<tr>
<td></td>
<td>1. At least five clinical quality measures across two of three categories (<em>eCQMs may submit only three measures</em>):</td>
</tr>
<tr>
<td></td>
<td>• Immunizations.</td>
</tr>
<tr>
<td></td>
<td>• Other preventive care.</td>
</tr>
<tr>
<td></td>
<td>• Chronic/acute care.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Clinical quality measures may not all come from one measure category.</td>
</tr>
<tr>
<td></td>
<td>2. At least one resource stewardship/utilization/health care cost measure (<em>eCQMs submit 1 measure</em>).</td>
</tr>
<tr>
<td></td>
<td>3. At least one patient experience measure or documentation of using a patient advisory council or other method of patient feedback.</td>
</tr>
<tr>
<td></td>
<td>For measures, submit:</td>
</tr>
<tr>
<td></td>
<td>1. The measure category (drop-down box). (CD)</td>
</tr>
<tr>
<td></td>
<td>2. The measure name. (CD)</td>
</tr>
<tr>
<td></td>
<td>3. The denominator description for the measure. (CD)</td>
</tr>
<tr>
<td></td>
<td>4. The numerator description for the measure. (CD)</td>
</tr>
<tr>
<td></td>
<td>5. The number of patients in the denominator (after exclusions). (Data, SS)</td>
</tr>
<tr>
<td></td>
<td>6. The number of patients in the numerator. (Data, SS)</td>
</tr>
<tr>
<td></td>
<td>7. <strong>Reporting period:</strong> The number of months for which the denominator is calculated (3–12 months). (Data, SS)</td>
</tr>
<tr>
<td></td>
<td>8. Was the measure a target for quality improvement in the past year? (Yes/No).</td>
</tr>
<tr>
<td>Requirements</td>
<td>Documentation/Data Required</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| Required     | Attest to quality improvement activities
|              | Fill out the QI worksheet for the top three priorities. (CD) |
|              | What are your practice’s top three QI activities? [open field] |
|              | 1.                          |
|              | 2.                          |
|              | 3.                          |
## Special Topic: Behavioral Health

Addressing the behavioral health needs of patients is an important aspect of comprehensive, whole-person care. In this section, NCQA seeks simply to understand the models used by recognized practices. Practices must submit the information about behavioral health based on the information outlined below. This special topic section is to help move practices towards better integration of behavioral health, but is not evaluated/scored to sustain PCMH recognition.

### Requirements

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Options</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informational</td>
<td>BH1. Identify eCQMs</td>
<td>1. Identify which eCQMs are monitored by the practice and reported. <em>(Note: drop-down menu will be available on the platform.)</em> (Data, SS)</td>
</tr>
</tbody>
</table>
| Informational        | BH2. Identify how behavioral health needs of patients are addressed    | 1. How does your practice address behavioral health needs of patients with the following behavioral health specialists? Check all that apply. *(CD)*  

#### a. Doctors of medicine (MD) or doctors of osteopathy (DO) who are state certified or licensed in psychiatry and/or addiction medicine
- Agreements with external behavioral health specialists
- Co-location with behavioral health specialist
- Behavioral health specialist is integrated within the practice
- None of the above
- Other _____________

#### b. Advanced practice registered nurses (APRN) (including nurse practitioners and clinical nurse specialists)
- Agreements with external behavioral health specialists
- Co-location with behavioral health specialist
- Behavioral health specialist is integrated within the practice
- None of the above
- Other _____________

#### c. Doctoral or master’s-level psychologists who are state certified or licensed
- Agreements with external behavioral health specialists
- Co-location with behavioral health specialist
- Behavioral health specialist is integrated within the practice
- None of the above
- Other _____________

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Options</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements</td>
<td>Options</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>---------</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**d.** Doctoral or master’s-level clinical social workers who are state certified or licensed.  
- □ Agreements with external behavioral health specialists  
- □ Co-location with behavioral health specialist  
- □ Behavioral health specialist is integrated within the practice)  
- □ None of the above  
- □ Other ________________

**e.** Doctoral or master’s-level marriage and family counselors who are state certified, registered or licensed by the state to practice independently.  
- □ Agreements with external behavioral health specialists  
- □ Co-location with behavioral health specialist  
- □ Behavioral health specialist is integrated within the practice  
- □ None of the above  
- □ Other ________________

**f.** Doctoral or master’s-level alcohol and drug counselors who are state certified, registered or licensed by the state to practice independently.  
- □ Agreements with external behavioral health specialists  
- □ Co-location with behavioral health specialist  
- □ Behavioral health specialist is integrated within the practice  
- □ None of the above  
- □ Other ________________

2. Provide a description of the patient “hand-off” process.
### Informational

#### BH3. Monitor access to appointments for behavioral healthcare (for all referrals combined)

Include data for all patients referred to any behavioral health specialist and report the following data:

1. **Denominator:** The number of initial behavioral health referrals. Include referrals to integrated behavioral health specialists, as well as to specialists in the community. (Data, SS)
2. **Numerator:** The number of referrals for which an appointment was scheduled. (Data, SS)
3. **Numerator:** The number of completed appointments or patients seen within 10 days of the referral. If the practice has an integrated behavioral health specialist and performs a warm hand-off at the time of the referral (patient is seen by the specialist on the same day the referral is made) this counts as an initial appointment. (Data, SS)
4. **Reporting period:** The number of months of data provided (3–12 months). (Data, SS)

#### IF USING MANUAL DATA

1. **Denominator:** 30
   How to select behavioral health referrals.
   Pick 30 consecutive behavioral health referrals from the past year (within 12 months prior to the reporting date). (Data, SS)
2. **Numerator:** Number of referrals for which an appointment was scheduled. Search the chart or tracking tool for the 30 behavioral health referrals and report how many had an appointment scheduled. (Data, SS)
3. **Numerator:** Number of completed appointments/patient seen within 10 days of the referral. Search the chart or tracking tool for the 30 behavioral health referrals and report how many have appointments were completed or patients were seen within 10 days of the referral. (Data, SS)
<table>
<thead>
<tr>
<th>Requirements</th>
<th>Options</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Informational</strong></td>
<td>BH4. Measure depression screening</td>
<td><strong>May be supported by</strong> <a href="#">prevalidation</a>. <strong>Identify tool.</strong> Drop-down with validated tools. (Attestation, CD)</td>
</tr>
</tbody>
</table>
| | | - PHQ-2  
| | | - PHQ-9  
| | | - Other ________________ |
| | | The practice defines:  
| | | 1. The patients included in the denominator (e.g., certain age groups, people without a history of depression). Open field. (Data, SS) |
| | | The practice provides the following data:  
| | | 2. **Denominator:** The number of patients. (Data, SS)  
| | | 3. **Numerator:** The number of patients screened. (Data, SS)  
| | | 4. Reporting period: Number of months (3-12 months) (Data, SS)  
| | | ☐ Check here if you’re using NQF-endorsed Measure 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan to report the numerator and denominator. |
| **Informational** | BH5. Measure anxiety screening | **Identify tool.** Drop-down with validated tools. (CD) |
| | | - **GAD-7 (Generalized Anxiety Disorder):** A seven-question screening tool that identifies whether a complete assessment for anxiety is indicated.  
| | | - **PC–PTSD:** A four-item screen designed for use in primary care and other medical settings to screen for post-traumatic stress disorder. It is currently used by the VA.  
| | | - Other ________________ |
| | | The practice defines:  
| | | 1. The patients included in the denominator (e.g., certain age groups, people without a history of anxiety). (Data, SS) |
| | | The practice provides the following data:  
| | | 2. **Denominator:** The number of patients. (Data, SS)  
| | | 3. **Numerator:** The number of patients screened. (Data, SS)  
<p>| | | 4. Reporting period: Number of months (3-12 months) (Data, SS) |</p>
<table>
<thead>
<tr>
<th>Requirements</th>
<th>Options</th>
<th>Documentation/Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informational</td>
<td>BH6. Provide decision support intervention for mental health or substance use disorder</td>
<td>May be supported by prevalidation (if the mental health/substance use disorder option is implemented).</td>
</tr>
</tbody>
</table>

1. Which topics does your practice address with decision support based on evidence-based guidelines? *(Note: This requirement focuses on treatment guidelines, not on screening guidelines.)*

**Mental Health Issues**
- Depression
- Anxiety
- Bipolar disorder
- ADHD/ADD
- Dementia/Alzheimer’s
- Other ____________

**Substance Use Issues**
- Illegal drug use
- Prescription drug addiction
- Alcoholism
- Other ____________
Maintenance of Certification Policy
Section 4:
Maintenance and Recertification

NCQA CCEs must continue to strengthen their knowledge base during their two-year certification period. In order to renew their credential, CCEs must complete the two required trainings identified in the table below, and select other continuing education events or activities to earn a total of 30 Continuing Education Unit (CEU) points within the two-year certification period. NCQA reserves the right to collect information and verify CEU activities.

At the time of any PCMH Recognition Program update (i.e. PCMH 2014 → PCMH 2017) all current PCMH CCEs will be required to take a live course or an online module by a specified date in order to remain current in their knowledge base of the PCMH program and retain their certification. PCMH CCEs not meeting this requirement by a specified deadline will be subject to suspension and/or possible revocation of their certificate.

CCEs are required to collect and maintain their documentation of continuing education. At the time of certification renewal, CCEs will be asked to complete their online renewal application and identify the continuing education and events they have completed. NCQA reserves the right to audit CCEs to ensure all requirements are met. If audited, CCEs must provide evidence of completion within 10 business days of audit notice. Failure to provide evidence will result in suspension and may lead to loss of certification.

### Required Continuing Education

<table>
<thead>
<tr>
<th>Quarterly Webinars for CCEs</th>
<th>CEU Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(activities offered live quarterly then archived, topics will vary)</em></td>
<td>2 credits each, for a required total of 8</td>
</tr>
</tbody>
</table>

Archived webinars can be found at:

### Available Webinars to date:

<table>
<thead>
<tr>
<th>Webinar Title</th>
<th>CEU Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Crosswalk Between the PCMH and PCSP Recognition Programs</td>
<td>2</td>
</tr>
<tr>
<td>The Building Blocks of an Individual Care Plan</td>
<td>2</td>
</tr>
<tr>
<td>First Comes Transformation! Innovative Ideas for Facilitating PCMH Recognition</td>
<td>2</td>
</tr>
<tr>
<td>Chronic Care Management: Why it Pays to Invest in Transformation</td>
<td>2</td>
</tr>
<tr>
<td>Practice Transformation and Quality Improvement—Why Include Patients?</td>
<td>2</td>
</tr>
<tr>
<td>Taking Those Critical First Steps—Self-Assessment and Gap Analysis</td>
<td>2</td>
</tr>
<tr>
<td>Documentation Miscues—Preparing a Strategy to Master the PCMH Must Pass Elements</td>
<td>2</td>
</tr>
<tr>
<td>Team Based Care—It Takes a Village to Transform a Medical Home</td>
<td>2</td>
</tr>
<tr>
<td>How to Effect Change as a PCMH Certified Content Expert</td>
<td>2</td>
</tr>
<tr>
<td>Arriving at PCMH 4A: Identifying Patients for Care Management using Lean Six Sigma</td>
<td>2</td>
</tr>
<tr>
<td>Town Hall Meeting for CCEs: PCMH 2017 Redesign</td>
<td>2</td>
</tr>
</tbody>
</table>

*CCEs are not limited to only 4 webinars and may attend additional webinars and earn credit.*

‘Required Continuing Education’ Listing continues on next page
### Required Continuing Education—cont’d.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Course Type</th>
<th>Registration Link</th>
<th>CEU Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCQA PCMH 2017 Recognition Product Update Training</strong></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>CCEs can choose from the following 3 options to complete this requirement by</td>
<td></td>
<td><strong>January 31, 2018</strong>*:</td>
<td></td>
</tr>
<tr>
<td><strong>Transitioning from PCMH 2014 to PCMH 2017: Commit, Transform, Succeed</strong></td>
<td>Online module</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td><strong>Transitioning from PCMH 2014 to PCMH 2017: Commit, Transform, Succeed</strong></td>
<td>Live, preconference at the PCMH</td>
<td><a href="http://pcmhcongress.com/content/rates-and-dates">http://pcmhcongress.com/content/rates-and-dates</a></td>
<td></td>
</tr>
<tr>
<td><strong>November 2, 2017</strong> Orlando, FL</td>
<td>Congress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*IMPORTANT: PCMH CCEs who are scheduled to expire before this deadline are not required to have this course completed in order to renew certification. However, we will give you credit towards your current renewal if you take it before your expiration. CCEs who wait until after their current renewal will have these credits applied to the next renewal window.

### Other Continuing Education

<table>
<thead>
<tr>
<th>Other Continuing Education</th>
<th>CEU Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced PCMH 2017: Succeeding in Medical Home Recognition</td>
<td>6</td>
</tr>
<tr>
<td>Introduction to ACO Accreditation (<em>live seminar</em>)</td>
<td>6</td>
</tr>
<tr>
<td>Patient-Centered Specialty Practice Recognition (<em>live seminar</em>)</td>
<td>6</td>
</tr>
<tr>
<td>Introduction to Case Management Accreditation (<em>live seminar</em>)</td>
<td>6</td>
</tr>
<tr>
<td>Introduction to HEDIS (<em>live seminar</em>)</td>
<td>6</td>
</tr>
<tr>
<td>NCQA’s Annual Policy Conference</td>
<td>3</td>
</tr>
<tr>
<td>Introduction to Patient-Centered Connected Care (<em>live seminar</em>)</td>
<td>6</td>
</tr>
<tr>
<td>A Toolbox for Transformation to the Patient-Centered Medical Home Webinar Series:</td>
<td>2</td>
</tr>
<tr>
<td>Tool #1 - Building the Foundation: The Joint Principles of the Patient Centered Medical Home</td>
<td></td>
</tr>
<tr>
<td>Tool #2 - Lessons from PCMH Change Champions</td>
<td></td>
</tr>
<tr>
<td>Tool #3 - Quality Resources for Developing Your PCMH Project Plan</td>
<td></td>
</tr>
<tr>
<td>Tool #4 - Tracking Technology: Maximizing Your Data and Information Systems to Improve Patient Care</td>
<td></td>
</tr>
<tr>
<td>(CCE must obtain a certificate of completion for each tool)</td>
<td></td>
</tr>
</tbody>
</table>

*Other Continuing Education’ Listing continues on next page
### Patient-Centered Connected Care Pre-Release Webinar for PCMH CCEs

- **CEU Credits**: 1

### PCMH Congress—October 9-11, 2015  San Francisco, CA

- **CEU Credits**: 21

### PCMH Congress—October 7-9, 2016  Chicago, IL

- **CEU Credits**: 15

### PCMH Congress—November 3-5, 2017  Orlando, FL

- **CEU Credits**: 15

### Navigating the Medical Home Neighborhood—July 29, 2015  Washington, DC

- **CEU Credits**: 5

### Strategies for Success as a Patient-Centered Medical Home

- **CEU Credits**: 6

### The Redesign of the PCMH Program *(webinar)*

- **CEU Credits**: 1

### Other Continuing Education—cont’d.

#### Introduction to HEDIS: The Webinar Series

<table>
<thead>
<tr>
<th>#1 – What is HEDIS?</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2 – HEDIS Date Sources</td>
<td>1</td>
</tr>
<tr>
<td>#3 – Measure Validation and HEDIS Data Submission</td>
<td>1</td>
</tr>
<tr>
<td>#4 – HEDIS and Accreditation</td>
<td>1</td>
</tr>
<tr>
<td>#5 – HEDIS Data Tools and Resources</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note: CCE must obtain a certificate of completion for each activity*

- **CEU Credits**: 1 credit each, for up to a total of 5

#### Patient Navigation is Not a “One Size Fits All” *(live webinar)*


- **CEU Credits**: 1

#### Denominators De-mystified: Guidance for Choosing and Using Measures in PCMH and PCSP *(live webinar)*


- **CEU Credits**: 1

#### Continuous Quality Improvement: Lean Six Sigma for PCMH Webinar Series

| Part 1 – Introduction to Lean | 1 |
| Part 2 – Process Mapping | 1 |
| Part 3 – What is Quality and How Do We Measure It? | 1 |
| Part 4 – Preparing for Failure | 1 |
| Part 5 – Making it Stick | 1 |
| Part 6 – Define, Measure, Analyze, Improve, Control (DMAIC) | 1 |

*Note: CCE must obtain a certificate of completion for each activity*

- **CEU Credits**: 1 credit each, for up to a total of 6


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*‘Other Continuing Education’ Listing continues on next page*
### Other Continuing Education—cont’d.

<table>
<thead>
<tr>
<th><strong>Quality Talks 2016—October 24, 2016</strong></th>
<th><strong>CEU Credits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From PCMH 2011 to PCMH 2014: A Transition Guide for Practices (web based on-demand)</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>PCSP 2016 Standards Update Webinar—April 28, 2016</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>HEDIS® Educational Webinar Series on Select Hybrid Measures Session 1 – Comprehensive Diabetes Care (CDC)</strong></td>
<td>1 credit each</td>
</tr>
</tbody>
</table>

*(CCE must obtain a certificate of completion for each activity)*


<table>
<thead>
<tr>
<th><strong>Referral to Specialists (live webinar)</strong></th>
<th><strong>CEU Credits</strong></th>
</tr>
</thead>
</table>


<table>
<thead>
<tr>
<th><strong>Care Management Transitions (live webinar)</strong></th>
<th><strong>CEU Credits</strong></th>
</tr>
</thead>
</table>


<table>
<thead>
<tr>
<th><strong>MACRA – An Overview of Industry Trends and Value-Based Payment (live webinar)</strong></th>
<th><strong>CEU Credits</strong></th>
</tr>
</thead>
</table>


### Tasks

Provide direct support to a practice to pursue NCQA PCMH Recognition either as a new applicant or a renewal of Recognition.

CCEs will be asked to list the name of the practice and the level achieved for Recognition.*

Documentation of support to a practice may include a letter on letterhead from the practice stating services provided and/or a copy of a services agreement or contract with a practice.

CCE’s can share points with each other if they are working as a team to assist practices.**

* MOC credit is prioritized for CCEs assisting practices that achieve NCQA PCMH Recognition. However, a CCE may receive credit for assisting a practice that does not receive recognition or has yet to receive a decision by the certification expiration date. This will require the CCE to provide an explanation as to why recognition what not achieved. Please Note: If audited, the CCE must provide supporting documentation.

** If 2 or more CCEs work as a team to assist practices, each CCE is eligible to receive the full amount of points listed for the task. Please Note: CCEs will be asked to list all members of the team on their renewal application.

### Single Site Support:

<table>
<thead>
<tr>
<th><strong>Tasks</strong></th>
<th><strong>CEU Credits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multi-sites Support:</strong></td>
<td></td>
</tr>
<tr>
<td>3 practice sites = 6 credits</td>
<td></td>
</tr>
<tr>
<td>4–10 practice sites = 8 credits</td>
<td></td>
</tr>
<tr>
<td>11–20 practice sites = 10 cr.</td>
<td></td>
</tr>
<tr>
<td>&gt;20 practice sites = 12 credits</td>
<td></td>
</tr>
</tbody>
</table>

*Tasks* Listing continues on next page
<table>
<thead>
<tr>
<th>Tasks—<em>cont’d.</em></th>
<th>CEU Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serve as <strong>faculty for NCQA trainings</strong> and seminars (by invitation only and at the discretion of NCQA, may not apply to all CCEs.)</td>
<td>3 per training</td>
</tr>
<tr>
<td>Serve as an <strong>NCQA reviewer</strong> for an NCQA Recognition program (by invitation only and at the discretion of NCQA, may not apply to all CCEs.)</td>
<td></td>
</tr>
<tr>
<td>CCEs will be asked to list the names of the practices and multi-site practices if applicable, for the reviews completed. Also, list each of the geographic practice sites that were part of the multi-site review.</td>
<td></td>
</tr>
<tr>
<td><strong>Additional RP Reviewer Credit:</strong></td>
<td></td>
</tr>
<tr>
<td>Reviewer Update Training —June 29, 2015 Washington, DC</td>
<td>3 points</td>
</tr>
<tr>
<td>Reviewer Update Training —June 22, 2016 Washington, DC</td>
<td>3 points</td>
</tr>
<tr>
<td>Content Training—February 16, 2017 <em>virtual training</em></td>
<td>1 point</td>
</tr>
<tr>
<td>Process Training—March 23, 2017 <em>virtual training</em></td>
<td>1 point</td>
</tr>
<tr>
<td>Review a Survey—March 30, 2017 <em>virtual training</em></td>
<td>1 point</td>
</tr>
<tr>
<td><strong>Single Site Reviews:</strong></td>
<td>1 per each practice site</td>
</tr>
<tr>
<td><strong>Multi-Site Reviews:</strong></td>
<td>1 per each practice site</td>
</tr>
<tr>
<td>Serve on the <strong>PCMH Advisory Committee</strong> (by invitation only and at the discretion of NCQA, may not apply to all CCEs.)</td>
<td>3 per initiative</td>
</tr>
<tr>
<td>Participate in the creation, development, and/or implementation of statewide initiatives*</td>
<td>3 per initiative</td>
</tr>
<tr>
<td>CCEs will be asked to provide the state, describe the scope of the project, and identify their role and responsibility.</td>
<td></td>
</tr>
<tr>
<td><em>CCEs will receive credit per overall initiative, not per task or role within the initiative.</em></td>
<td></td>
</tr>
</tbody>
</table>

At the end of the two-year certification, CCEs have the option to renew and maintain the PCMH CCE credential. Thirty (30) days prior to the certification expiration date, Applied Measurement Professionals (AMP), our renewal application vendor, will contact the CCE via e-mail with details about how to pursue certification renewal.

Please note that at the time of renewal, CCEs will be expected to provide a list of the practices they have assisted with Recognition preparations during the past 2 years. In the case of an audit, CCEs will be asked to provide documentation for all **required continuing education, other continuing education, and tasks** that they attested to in the application.