AGREEMENT FOR NCQA PATIENT-CENTERED MEDICAL HOME (PCMH) RECOGNITION PROGRAM

The individual or organization designated below is referred to as the "Practice," and by submission of its designee's signature, agrees to the terms from the National Committee for Quality Assurance, or "NCQA," for Practice's participation in NCQA's PCMH Recognition Program.

This Agreement is effective on the date signed by NCQA and remains in effect following the Practice's enrollment in NCQA's PCMH Recognition Program and through the evaluation process, any criteria denial or recognition status decision, and all subsequent renewals. Practice agrees that in addition to the obligations under this Agreement, the Practice agrees to abide by and be bound by the policies and procedures for NCQA's PCMH Recognition Program that are in effect at the time Practice undergoes its NCQA survey, and as updated from time to time, including without limitation:

- NCQA's PCMH Standards and Guidelines that describe eligibility criteria, the process for seeking and sustaining NCQA PCMH Recognition, and notification requirements of recognized practices.
- NCQA's Guidelines for Advertising and Marketing that describe how recognized practices can promote their NCQA status and restrictions for marketing recognition status.
- NCQA Fee Schedules that establish survey pricing and payment policies.

Practice agrees to these additional terms for participation in NCQA's PCMH Recognition Program:

1. Practice agrees to provide only true, accurate and complete information to NCQA, and to make available to NCQA and its surveyors, reviewers, auditors, and members of the Review Oversight Committee and Reconsideration Committee information and materials about Practice and its clinicians to verify what appears in the application materials, survey tools, and data submissions. Practice also agrees that NCQA may provide to an NCQA-Certified credentialing verification organization licensure and other information to verify.
2. If recognized by NCQA, Practice agrees to continue to meet the requirements of PCMH recognition during the life of Practice's recognition. Practice must report to NCQA the occurrence of any reportable event in accordance with the PCMH Recognition Program policies and procedures, including without limitation a change in practice location, clinicians listed with the Practice or licensure or qualification status of a clinician, final determination by a state or federal agency with respect to an investigation, material change in structure or operation of the Practice, or the merger, acquisition or consolidation of the Practice. Practice also agrees to submit to audits, investigations, and discretionary reviews as described in the policies and procedures.
3. Practice understands and agrees that NCQA reserves the right to release and publish, and authorize others to publish, Practice's results under specific reporting categories, competencies, and criteria, including annual reporting and distinctions, and to use aggregate data about Practice and its clinicians as described in the policies and procedures for NCQA's PCMH Recognition Program.

NCQA bears no responsibility for any use by third parties of the results or data, or for any effect of such release and publication on Practice.

4. NCQA also reserves the right to notify applicable licensing authorities and regulatory agencies if aspects of the Practice's operations pose a potential imminent threat to the health and safety of its patients and/or NCQA has reason to believe that information submitted to NCQA is fraudulent or has been falsified.

5. If recognition under NCQA's PCMH Recognition Program results in monetary rewards from purchasers, plans or others tied to quality, Practice understands and agrees that NCQA neither recommends nor decides whether or to what extent Practice should or will receive such rewards. Practice also agrees that NCQA PCMH Recognition is not transferable to any other person or organization unless approved by NCQA. Practice's recognition status is subject to change as described in the policies and procedures of NCQA's Recognition Program.

6. The deliberations of NCQA, its surveyors, reviewers, auditors, and members of the Review Oversight Committee and Reconsideration Committee information are considered and treated as peer review materials generated for the purpose of reviewing the professional services of Practice, notwithstanding any statutes, case law or other authority that would not recognize such information as peer review materials. Practice understands and agrees that the survey of the Practice and annual assessment does not constitute a warranty or representation of any kind by NCQA regarding the quality or nature of Practice's services.

7. Practice agrees to indemnify NCQA from and against any and all liability, loss, or damages arising from (1) third party claims regarding the quality or nature of the health care services provided or arranged by Practice or Practice's non-fulfillment of its obligations under this Agreement and NCQA's PCMH Standards and Guidelines; (2) the Practice's failure to achieve desired results under NCQA's PCMH Recognition Program; or (3) payment and network decisions made by third parties based on Practice's status under NCQA's PCMH Recognition Program; provided, that this provision shall not apply to the extent Practice is an institution of a state government, a political subdivision of a state or otherwise afforded sovereign immunity under applicable law. In no event, will NCQA be responsible for any claims or demands of third parties, or any lost profits, loss of business, loss of use, lost savings, or other consequential, special, incidental, indirect, exemplary, or punitive damages, even if advised of the possibility of such damages.

8. Practice will not provide to NCQA protected health information, as that term is defined under HIPAA and the Federal privacy and security regulations established at 45 C.F.R. Parts 160 and 164, as amended from time to time, unless requested by NCQA. If NCQA requests a patient example, Practice will provide a de-identified example that blocks or removes any element of protected health information. If NCQA requests an element of protected health information in evidence, such as a date of service, then Practice agrees to only provide the minimum necessary to satisfy the NCQA criteria. NCQA does not request, and a Practice should never submit evidence with patient names, social security numbers, street or email addresses, or telephone numbers to satisfy NCQA criteria. NCQA may see protected health information during virtual check-ins or an investigation as described in the PCMH Standards and Guidelines. Practice and NCQA acknowledge that they will enter into, or have entered into a Business Associate Agreement, which governs any use and disclosure of protected health information for purposes of Practice' health care quality assessment and review by NCQA and satisfaction of NCQA's criteria.

9. Any and all claims or actions arising under this Agreement shall be governed by the law of the District of Columbia regardless of any applicable conflicts of laws principles, and shall be exclusively resolved by a court of competent jurisdiction within the District of Columbia; provided, that this provision shall not apply if Practice is an institution of a state government, a political subdivision of a state or otherwise afforded sovereign immunity under applicable law.

10. A waiver of any term or condition by either party shall not constitute a waiver of any other term or condition under this Agreement, and nothing in this Agreement shall be deemed an express or implied waiver of sovereign immunity by Practice, if applicable. Sections 2, 5, 7 and 8 shall survive expiration of this Agreement or Practice's withdrawal from or loss of NCQA PCMH Recognition. This Agreement is binding on the parties' successors and permitted assigns.

THE PRACTICE AGREES TO ENTER INTO THIS AGREEMENT BY MEANS OF ELECTRONIC SIGNATURE. THE PERSON SIGNING BELOW REPRESENTS THAT BY TYPING IN AND SUBMITTING THEIR ELECTRONIC SIGNATURE TO NCQA, THEY BIND PRACTICE TO THE TERMS OF THIS AGREEMENT AND ARE AUTHORIZED TO VALIDLY ENTER INTO AND BIND PRACTICE TO THE TERMS OF THIS AGREEMENT. THIS AGREEMENT MAY ONLY BE MODIFIED IN WRITING.

Print Name of Practice: _____

By: _____

Name/Title: _____

Date: _____

National Committee for Quality Assurance

By: _____

Name/Title: _____

Date: _____

Monterey County Deputy County Counsel

Date: 12/7/18

Monterey County Deputy Auditor/Controller

Date: 12-10-18

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "BAA") is entered into between the National Committee for Quality Assurance ("NCQA") and the individual or entity whose signature appears below as evidence of agreement to these the terms hereinafter referred to as "Covered Entity." This BAA and any agreement for accreditation, certification, distinction, or recognition entered into by Covered Entity and NCQA establish the terms of the relationship between NCQA and Covered Entity.

WHEREAS, Covered Entity is seeking accreditation, certification or recognition by NCQA and may disclose data to NCQA and input data into data collection tools stored and maintained by NCQA, which data may include certain Protected Health Information (as defined in 45 C.F.R. § 160.103) that is subject to protection under the Federal Privacy, Security, Breach Notification, and Enforcement Rules established at 45 C.F.R. Parts 160 and 164, as amended from time to time (collectively the "HIPAA Rules"), promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 ("ARRA");

WHEREAS, NCQA may act in the role of a Business Associate (as defined in 45 C.F.R. § 160.103) for purposes of Covered Entity's health care quality assessment and review by NCQA and satisfaction of NCQA's standards and requirements and the HIPAA Rules dictate that the Covered Entity shall enter into an agreement with a Business Associate to whom it provides PHI, and this BAA shall apply to that PHI;

WHEREAS, Covered Entity may have entered into, may subsequently enter into, or may enter into simultaneously with this BAA, an agreement with NCQA to seek accreditation, certification or recognition and apply for an NCQA survey (hereinafter any such agreement will be referred to as a "Contract") and this BAA shall be applicable to any such Contract entered into by Covered Entity and NCQA when NCQA acts as a Business Associate of Covered Entity, as defined under the HIPAA Rules; and

WHEREAS, the purpose of this BAA is to satisfy certain standards and requirements of the HIPAA Rules, as the same may be amended from time to time.

NOW THEREFORE, in consideration of the mutual promises below, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

I. GENERAL PROVISIONS

Section 1. **Definitions.** Unless otherwise specified in the Contract or this BAA, all capitalized terms used herein and not otherwise defined shall have the meanings established by

45 C.F.R. Parts 160 and 164, as amended from time to time. "PHI" shall mean Protected Health Information, as defined in 45 C.F.R. § 160.103, limited to the information received from or on behalf of Covered Entity. "Electronic PHI" shall mean Electronic Protected Health Information, as defined in 45 C.F.R. § 160.103, limited to the information received from or on behalf of Covered Entity. The terms "use" and "disclosure" and any and all other terms with defined meanings established by 45 C.F.R. Parts 160 and 164, as amended from time to time, shall have the same meaning for the purpose of this BAA. References in the Contract or this BAA to a section or subsection of 45 C.F.R. Parts 160 and 164, and/or ARRA under Title 42 of the United States Code are references to provisions of ARRA and shall be deemed a reference to that provision and its existing and future implementing regulations, when and as each is effective and compliance is required under the applicable provision.

Section 2. **Effect.** This BAA shall apply to any PHI subject to the Contract and to any PHI disclosed by Covered Entity for purposes of Covered Entity's health care quality assessment by NCQA and satisfaction of NCQA's standards and requirements and using data collection tools stored and maintained by NCQA. Any provision of the Contract, including all exhibits or other attachments thereto and all documents incorporated therein by reference, that is directly contradictory to one or more terms of this BAA ("Contradictory Term"), shall be superseded by the terms of this BAA to the extent and only to the extent of the contradiction and only to the extent that it is reasonably impossible to comply with both the Contradictory Term and the terms of this BAA. Notwithstanding anything in this Agreement to the contrary, nothing in this BAA shall alter the rights and obligations of the respective parties under the HIPAA Rules.

II. RESPONSIBILITIES OF NCQA

Section 1. **Use and Disclosure of Protected Health Information.** NCQA may:

(a) use and/or disclose PHI only in the fulfillment of the Contract, this BAA, or as Required By Law, and in compliance with each applicable requirement of 45 C.F.R. § 164.504(e);

(b) use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of NCQA;

(c) disclose PHI in its possession to a third party for the purpose of NCQA's proper management and administration or to fulfill any legal responsibilities of NCQA if the disclosures are Required by Law, and NCQA has received from the third party written assurances that (i) the information will be held confidentially and be used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the third party, and (ii) the third party will notify NCQA (and, in accordance with Article II, Section 3 of this BAA, NCQA shall notify Covered Entity) of any instances of which it becomes aware in which the confidentiality of the information has been breached;

(d) create a Limited Data Set and use and disclose such Limited Data Set pursuant to the Data Use Agreement as set forth in Article VI of this BAA; and

(e) de-identify PHI obtained by NCQA under this BAA and/or the Contract, and use and/or disclose such de-identified data in the fulfillment of the Contract or this BAA, and in compliance with the de-identification requirements of the HIPAA Rules.

NCQA shall request, use and/or disclose the minimum amount of PHI necessary with regard to its use and/or disclosure of PHI under this Section 1. NCQA shall not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity. All other uses and disclosures of PHI not authorized by this BAA or the Contract are prohibited. NCQA acknowledges that it may be subject to the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the use and disclosure requirements and any guidance issued by the Secretary from time to time.

Section 2. **Appropriate Safeguards.** NCQA will use appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI, other than as provided for by the Contract, this BAA or as Required by Law, in accordance with the requirements set forth in Subpart C of 45 C.F.R. Part 164, including implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. NCQA will also keep current and document such security measures in written policies, procedures or guidelines, and make its policies and procedures, and documentation relating to such safeguards, available to the Secretary in accordance with the HIPAA Rules.

Section 3. **Reporting of Improper Use or Disclosure of PHI.** NCQA will within ten (10) business days of becoming aware of any use or disclosure of PHI not permitted or required by the Contract or this BAA, or of any Security Incident with respect to Electronic PHI of which it becomes aware, report such use, disclosure or Security Incident to Covered Entity. NCQA agrees to mitigate, to the extent practicable, any harmful effect that is known to NCQA of a use or disclosure of PHI by NCQA in violation of the requirements of this BAA. NCQA further agrees to report without unreasonable delay, and in no case later than thirty (30) calendar days after discovery, any Breach of any Unsecured PHI in accordance with the security breach notification requirements set forth in 45 C.F.R. §§ 164.400, 164.402, and 164.410 and any guidance issued by the Secretary from time to time.

Section 4. **Subcontractors and Agents.** NCQA agrees that any time PHI is provided or made available to its subcontractors or agents, NCQA will enter into an agreement with the subcontractor or agent that contains the same conditions and restrictions on the use and disclosure of PHI as contained in the Contract and this BAA in accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, and will ensure that all of its subcontractors and agents to whom it provides Electronic PHI agree to implement reasonable and appropriate safeguards to protect such Electronic PHI.

Section 5. **Right of Access, Amendment and Accounting of Disclosures**. With respect to the PHI in NCQA's possession, NCQA agrees to the following:

(a) within fifteen (15) calendar days of receiving a written request from Covered Entity, NCQA will make available to Covered Entity information necessary for Covered Entity to make an Accounting of Disclosures of PHI about an Individual in accordance with the Privacy

Regulations as set forth in 45 C.F.R. § 164.528 and, in accordance with the requirements for Accounting for Disclosures made through an Electronic Health Record in 42 U.S.C. 17935(c), and when directed by Covered Entity, NCQA shall make that accounting directly to the Individual.

(b) NCQA shall record the following information regarding each disclosure of PHI subject to an Accounting of Disclosures pursuant to 45 C.F.R. § 164.528: (1) date of disclosure; (2) name of entity or person who received the PHI and, if known, the address of such entity or person; (3) a brief description of the PHI; and (4) a brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure or a copy of a written request for disclosure. For multiple such disclosures of PHI to the same person or entity for a single purpose, NCQA shall provide Covered Entity, pursuant to Article II, Section 5(a) of this BAA, (1) the information set forth in Article II, Section 5(b) of this BAA regarding the first disclosure; (2) the frequency, periodicity or number of disclosures made during the accounting period; and (3) the date of the last such disclosure during the accounting period.

(c) make available its internal practices, books, and records relating to the use and disclosure of PHI to the Secretary of the Department of Health and Human Services in accordance with the HIPAA Rules ; and

(d) forward to Covered Entity within five (5) business days of receiving any requests an Individual makes of NCQA pursuant to 45 C.F.R. §§ 164.524 or 164.526, so that Covered Entity may respond to such requests. NCQA shall not respond directly to those Individual requests.

Section 6. **Exchange of PHI and Communications.** NCQA agrees to the following:

(a) NCQA shall not directly or indirectly receive remuneration in exchange for any PHI in compliance with 45 C.F.R. §§ 164.502(a)(5), 164.504(e)(2)(i), and 164.508(a);

(b) NCQA shall not make or cause to be made any communication about a product or service that is prohibited by45. C.F.R. §§ 164.502(a)(5), 164.504(e)(2)(i), and 164.508(a);

(c) NCQA shall not make or cause to be made any written fundraising communication that is prohibited by 45 C.F.R. § 164.514(f).

III. OBLIGATIONS OF COVERED ENTITY

Section 1. **Limitations on Protected Health Information.** Covered Entity agrees that it will not furnish to NCQA any PHI that is subject to any restrictions on the use and/or disclosure of PHI as provided for in 45 C.F.R. § 164.522 that will affect NCQA's use or disclosure of the PHI under this BAA; provided that, with respect to restrictions that Covered Entity is required to agree to under 45 C.F.R. § 164.522(a), Covered Entity shall provide NCQA with clear written notice of those restrictions and the PHI to which they pertain.

Section 2. **Compliance with HIPAA and ARRA**. Covered Entity in performing its obligations and exercising its rights under this Agreement shall use and disclose Protected Health Information in compliance with the HIPAA Rules and ARRA. Covered Entity agrees that it will

not provide to NCQA PHI unless expressly requested by NCQA in the fulfillment of the Contract.

Section 3. **Covered Entity Requests**. Covered Entity shall not request or require NCQA to use or disclose Protected Health Information in any manner that would not be permissible under Subpart E of 45 C.F.R. Part 164 if done by Covered Entity.

IV. TERMINATION OF AGREEMENT

Section 1. **Termination of Agreement by Covered Entity.** Upon Covered Entity's knowledge of a breach of a material term of this BAA by NCQA, Covered Entity shall provide NCQA with written notice of that breach in sufficient detail to enable NCQA to understand the specific nature of that breach and afford NCQA the opportunity to cure the breach; provided, however, that if NCQA fails to cure the breach within a reasonable time specified by Covered Entity, Covered Entity may terminate this BAA. Upon termination of this BAA under this Section, NCQA will comply with the return or destruction provisions of Article IV, Section 3 below, and Covered Entity may terminate the Contract, unless the parties mutually agree that NCQA may review Covered Entity pursuant to the Contract using only a Limited Data Set, pursuant to the Data Use Agreement in Article VI of this BAA, or with information that has been de-identified. If after termination of this BAA pursuant to this Section the parties agree that NCQA will continue its review of Covered Entity under the Contract using a Limited Data Set or de-identified information, the Contract shall continue in effect and the terms of this BAA that apply to such review of Covered Entity pursuant to the Contract shall survive to the extent necessary for NCQA to conduct the Survey of Covered Entity.

Section 2. **Termination of Agreement by NCQA.** Upon NCQA's knowledge of a breach of a material term of this BAA by Covered Entity, NCQA shall provide Covered Entity with written notice of that breach in sufficient detail to enable Covered Entity to understand the specific nature of that breach and afford Covered Entity the opportunity to cure the breach; provided, however, that if Covered Entity fails to cure the breach within a reasonable time specified by NCQA, NCQA may terminate this BAA as well as terminate the Contract.

Section 3. **Return or Destruction of PHI.** Within thirty (30) calendar days after termination or expiration of the Contract or this BAA, NCQA agrees to either return to Covered Entity or destroy all PHI received from the Covered Entity or created or received by NCQA on behalf of the Covered Entity and which NCQA still maintains in any form, including such information in possession of NCQA's subcontractors. NCQA agrees not to retain any copies of such PHI. If return or destruction of the PHI is not feasible, NCQA agrees to extend the protections, limitations and restrictions of this BAA to NCQA's use and disclosure of PHI retained after termination and to limit any further uses or disclosures to the purposes that make return or destruction infeasible. Any de-identified information retained by NCQA shall not be re-identified except for a purpose permitted under this BAA.

V. LIMITATION OF LIABILITY

Section 1. **Hold Harmless.** Each party agrees to hold harmless the other party to this BAA from and against any and all claims, losses, liabilities, costs and other expenses (including

reasonable attorney fees and costs associated with any suits, actions, proceedings, claims, or official investigations or inquiries) incurred as a result of: (i) any misrepresentation or non-fulfillment of any undertaking on the part of the party pursuant to this BAA; and (ii) negligent or intentional acts or omissions in the party's performance under this BAA. In no event will a party be responsible for any damages, caused by the failure of the other party to perform its responsibilities. If Covered Entity is an institution of a state government or a political subdivision of such state, this Article V shall apply only to the extent permitted under applicable state law, and nothing herein shall be deemed an express or implied waiver of sovereign immunity.

Section 2. **Damages.** NO PARTY SHALL BE LIABLE TO ANOTHER PARTY HERETO FOR ANY INCIDENTAL, CONSEQUENTIAL, SPECIAL, OR PUNITIVE DAMAGES OF ANY KIND OR NATURE RELATING TO OR ARISING FROM THE PERFORMANCE OR BREACH OF OBLIGATIONS SET FORTH IN THIS BAA, WHETHER SUCH LIABILITY IS ASSERTED ON THE BASIS OF CONTRACT, TORT (INCLUDING NEGLIGENCE OR STRICT LIABILITY), OR OTHERWISE, EVEN IF THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH LOSS OR DAMAGES.

VI. DATA USE AGREEMENT

Section 1. **Preparation of the Limited Data Set.** In accordance with Article II, Section 1(d) of this BAA NCQA may, on behalf of Covered Entity, prepare a Limited Data Set ("LDS") in accordance with the requirements set forth in this BAA.

Section 2. **Minimum Necessary Data Fields in the LDS.** In preparing the LDS, NCQA will include the data fields which are the minimum necessary to accomplish the purposes set forth in Section 4 of this Article VI.

Section 3. **Responsibilities of NCQA.** All of the restrictions, obligations, requirements and conditions of this BAA shall apply to such LDS in the same manner as they apply to PHI under this BAA. NCQA agrees to not use or further disclose the LDS other than as permitted by this Article VI or as otherwise Required by Law. NCQA further agrees that it will not identify the information in the LDS or contact the Individuals whose PHI is in the LDS, except where such contact is based on information derived entirely from a source other than the LDS.

Section 4. **Permitted Uses and Disclosures of the LDS.** NCQA may use and/or disclose the LDS for its Research and Public Health activities and the Health Care Operations of the Covered Entity.

VII. MISCELLANEOUS

Section 1. **Choice of Law and Jurisdiction.** The law of the District of Columbia shall govern this BAA. The parties agree that any dispute arising under this BAA shall only be resolved in a court of competent jurisdiction in the District of Columbia. Notwithstanding the foregoing, this choice of law and venue provision shall not apply if Covered Entity is an institution of a state government and afforded sovereign immunity under applicable state law.

Section 2. **Change in Law.** The parties agree to negotiate to amend this BAA (a) as necessary to comply with any amendment to any provision of HIPAA or its implementing regulations, ARRA, or to comply with any other applicable laws or regulations, or amendments thereto, and/or (b) in the event any such law or regulation or amendment thereto materially alters either party or both parties' obligations under this BAA. The parties agree to negotiate in good faith mutually acceptable and appropriate amendment(s) to this BAA to give effect to such revised obligations. If the parties are unable to agree to mutually acceptable amendment(s) within sixty (60) calendar days of the relevant change in law or regulations, either party may terminate this BAA and the Contract consistent with the terms of this BAA and the Contract. Notwithstanding the preceding sentence, the parties agree that this BAA is written to encompass ARRA and its implementing regulations.

Section 3. **Third Party Beneficiaries.** Nothing in this BAA shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Section 4. **Survival.** Article I; Article II; Article IV, Section 3; and Article V, and Article VII of this BAA shall survive termination of this BAA and continue indefinitely solely with respect to PHI NCQA retains in accordance with Article IV, Section 3. Article VI shall survive the termination of this BAA with regard to any LDS that NCQA possesses. The last sentence of Article IV Section 1 shall survive termination of this BAA with regard to any de-identified information NCQA creates using Covered Entity's PHI.

Section 5. **Notice.** Any notice, consent, request or waiver, or other communications to be given hereunder by either party shall be given in writing and will be deemed to have been given when delivered personally or by registered mail, postage prepaid and return receipt requested or by facsimile with a confirming copy placed in the United States mail addressed as provided below or to such other address as either party may designate by written notice to the other.

If to NCQA:
National Committee for Quality Assurance
1100 13th Street, NW, Third Floor
Washington, DC 20005
Attention: General Counsel and Chief Privacy Officer
Fax: 202-955-3599

If to Covered Entity:

Name of Individual/Entity: _____

Address: _____

City/State/Zip: _____

Fax: _____

The parties acknowledge that it is their intent to enter into this BAA by means of electronic signature. The person entering into this BAA on behalf of Covered Entity represents that by electronically signing this Agreement and by typing in and submitting their electronic signature to NCQA, they hereby bind the Covered Entity to the terms of this BAA and further, that such individual signing is authorized to validly enter into and bind Covered Entity to the terms of this BAA.

For Covered Entity:

By: _____

Print Name: _____

Title: _____

Date: _____

For National Committee for Quality Assurance

By: _____

Print Name: _____

Title: _____

Date: _____

Advertising and Marketing Guidelines

Recognition Programs

Introduction

Congratulations on achieving recognition. We encourage you to publicize your achievement and have developed the following Advertising and Marketing Guidelines to help you get the most out of your recognition. The guidelines include how to market your achievement, appropriate language to incorporate into your marketing, advertising materials and helpful ideas to get you started.

Guidelines for each recognition program are also included to provide more detailed information about specific recognition programs (e.g. Heart/Stroke, Diabetes, and Patient-Centered Medical Home). Refer to these guidelines for appropriate language to promote your program-specific recognition.

- Diabetes Recognition
- Heart/Stroke Recognition
- Patient-Centered Medical Home Recognition
  - Behavioral Health Integration Distinction
- Patient-Centered Specialty Practice Recognition
- Oncology Medical Home Recognition
- School-Based Medical Home Recognition

The guidelines below are to be used in conjunction with NCQA's Guidelines for Advertising and Marketing (**www.ncqa.org/NCQAguidelines**).

Use of Recognition Seals

NCQA encourages clinicians that have received recognition to display their seals in marketing and advertising materials.

- There are individual seals for each program.
- You can access the seals at **www.ncqa.org/seals**
- Seals are provided in EPS and JPG formats.
- Seals must not be manipulated in any way, shape or form.
- Seals should be displayed in a readable format and the overall depiction should be consistent with NCQA's graphical image.

Organizations should be aware that NCQA may update program seals. Organizations should check periodically to ensure that they are using the most recent and program-appropriate seal.

Guidelines for Advertising and Marketing Recognitions

Below are guidelines to help you correctly communicate your achievement.

- All statements about recognition **must** be accurate, clearly stated and represent the clinician's, group's or practice's actual recognition status.
- Reference to recognition **must** clearly indicate the name of the clinician, group or practice as stated on the recognition certificate.

- Advertising language **must** indicate the full name of the recognition program
- Examples of suitable language are:
  - "Medical Group B, at its Town A, Town B, and Town C offices, has been awarded recognition by the National Committee for Quality Assurance Patient-Centered Medical Home Program."
  - "John Doe, M.D., has been awarded recognition by the National Committee for Quality Assurance Heart/Stroke Recognition Program."
- You may state that you are the first clinician or practice in the program to receive recognition in a city or state if the statement is accurate and can be proven by the clinician or practice that is stating it. Practices and clinicians can only use the city or state listed in their postal address on the recognition application. The name of the program must be clearly stated.
  - Example: "Physician Group A is the first physician group in Delaware to receive NCQA Patient-Centered Medical Home Recognition."
  - Example: "Cardiology Practice B is the first practice to receive NCQA Patient-Centered Specialty Practice Recognition in Arlington, VA.
- You may not refer to a "region" when discussing the recognized clinician(s) or practice.
  - This example is not permissible: "Physician Group A was the first physician group in the region (or even naming the region, e.g. South Texas) to receive NCQA Patient-Centered Medical Home Recognition."
- Recognition is not a ranking or rating system, or a certification or accreditation program, and should not be referred to as such.
- When advertising recognition status, a clinician, group or practice must always report its most current recognition status. You may also choose to describe recognition history, i.e., the results from previous recognition applications.
  - Example 1: "Clinician X of Group A has received three-year recognition from the National Committee for Quality Assurance Heart/Stroke Recognition Program. Clinician X also received recognition three years ago."
  - Example 2: "Clinician X of Group A was recognized under the National Committee for Quality Assurance PPC-PCMH program from 2008-2011."
- Individual clinician or practice results from any of the recognition programs may be promoted but are limited to "Recognized" or "Recognized at level X."
- Clinicians, groups or practices may only list their own results or date. No comparisons to other clinicians, groups or practices are permitted.
- Advertising material **must** not contain any reference to or quotations from any report, correspondence or other materials prepared in connection with NCQA's evaluation of the application.
- Advertising material should not state or imply that recognition is an endorsement, guarantee, or certification of the clinician, group, practice, services, staff or facilities; NCQA or any person or organization associated with NCQA, or that there is any formal connection between the clinician or practice, NCQA and and/or any person or organization associated with NCQA. (For example, a clinician cannot represent its recognition as being awarded by or associated with any NCQA officer, employee, director or organization that was collaborating with NCQA).

Recommended Language

Any of the following statements may be used to describe your recognition and NCQA. It may be used alone or, in combination with other language, to identify or describe NCQA, the recognition process or recognition status.

Descriptions of NCQA

NCQA is a private, nonprofit organization dedicated to improving health care quality.

- NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS®, the performance measurement tool used by more than 90 percent of the nation's health plans.
- NCQA's website contains information to help consumers, employers and others make more informed health care choices.
- NCQA is governed by a Board of Directors that includes employers, consumers, health plans, quality experts, and representatives from organized medicine.
- NCQA's Web site (ncqa.org) contains information to help consumers, employers and others make more informed health care choices.
- NCQA's mission is to improve the quality of health care.

Descriptions of Recognition Programs

- The National Committee for Quality Assurance has awarded an accreditation status of level 2 for demonstrating a broad range of capabilities of an Accountable Care Organization.
- The Recognition Programs assess whether clinicians and practices support the delivery of high-quality care.
- The Recognition Programs are built on evidence-based, nationally recognized clinical standards of care.
- The official NCQA directory of Recognized Clinicians can be accessed at **http://recognition.ncqa.org**

Health Plan Promotion of Recognition

Health Plans are encouraged to promote their support of recognition. The above guidelines should be followed and can be applied to all marketing and advertising campaigns.

Health Plans can promote recognition as follows:

- Adding recognition program seals to clinician directories
- Supporting network clinicians who participate in recognition programs by assisting with data collection efforts
- Providing financial support such as reimbursement of application fees or Pay-for-Performance incentives

Recognition Program Data

Health Plans can obtain data from the recognition programs from NCQA in a monthly data feed format, eliminating the burden of manually identifying new clinicians from the published list. For more information about this, licensing for the recognition program data for custom resale tools or directory materials, please contact NCQA at **informationproducts@ncqa.org**.

Program-Specific Information

This section contains information specific to each recognition program. It includes appropriate language to describe each program and quotes associated with the individual recognition program. We encourage you to integrate this information into your marketing and advertising materials when referring to an individual recognition program.

Diabetes Recognition

Approved Language

- NCQA's Diabetes Recognition Program recognizes clinicians who have met standards demonstrating delivery of high-quality care to patients with diabetes.
- The NCQA Diabetes Recognition Program is a voluntary effort to identify clinicians who provide diabetes care consistent with the comprehensive diabetes care measures within the Healthcare Effectiveness Data and Information Set (HEDIS®)
- Clinicians who achieve DRP Recognition show their peers, patients and others in the Diabetes community that they are part of an elite group that is publicly recognized for its skill in providing the highest-level diabetes care.

Approved Quotes

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"NCQA's Diabetes Recognition Program honors the vanguard, professionals using the best science to help patients cope with one of modern life's most pervasive illnesses," said NCQA President Margaret E. O'Kane. "I commend [PRACTICE/PHYSICIAN NAME] for providing high quality care and for going the extra mile to help people with diabetes."

"For a person with diabetes, the right clinician can make the difference between living with diabetes as opposed to suffering from diabetes," said Margaret E. O'Kane, President, National Committee for Quality Assurance. "By earning recognition, [CLINICIAN] has demonstrated that [HE/SHE] provides effective, evidence-based care to [HIS/HER] patients with diabetes."

Heart/Stroke Recognition

Approved Language

- NCQA's Heart/Stroke Recognition means that clinicians have met standards showing they are providing high quality, evidence–based care for their CVD and stroke patients.
- This voluntary program is designed to recognize clinicians who have met standards demonstrating delivery of high-quality care to patients with cardiovascular disease and/or stroke.

Approved Quotes

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"Controlling blood pressure and quitting smoking are common-sense treatments for cardiovascular disease. But the number of clinicians who don't urge their patients who smoke to quit would surprise you," said NCQA President Margaret E. O'Kane. "The Heart/Stroke Recognition Program identifies clinicians who follow these evidence-based guidelines. [CLINICIAN NAME] is to be commended for [HIS/HER] achievement in earning Recognition."

"For a person with cardiovascular issues, the right clinician can make the difference between living with cardiovascular issues as opposed to suffering from cardiovascular issues," said Margaret E. O'Kane, President, National Committee for Quality Assurance. "By earning recognition, [CLINICIAN NAME] has demonstrated that [HE/SHE] provides effective, evidence-based care to [HIS/HER] patients with cardiovascular issues."

Patient-Centered Medical Home Recognition

Approved Language

- The NCQA Patient-Centered Medical Home program reflects the input of the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA) and others.
- It was developed to assess whether clinician practices are functioning as medical homes and recognize them for these efforts.
- The NCQA Patient-Centered Medical Home standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement.

Approved Quote

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"NCQA Patient-Centered Medical Home Recognition raises the bar in defining high-quality care by emphasizing access, health information technology and coordinated care focused on patients," said NCQA President Margaret E. O'Kane. "Recognition shows that [PRACTICE NAME] has the tools, systems and resources to provide its patients with the right care, at the right time."

Behavioral Health Integration Distinction

Approved Language

- Primary care practices that earn NCQA's Distinction in Behavioral Health Integration have put the right resources, evidence-based protocols, standardized tools and quality measures in place to support the broad needs of patients with behavioral health conditions.
- PCMH Distinction in Behavioral Health Integration distinguishes practices that provide integrated behavioral healthcare and services as a part of a patient-centered medical home.
- PCMH Distinction in Behavioral Health Integration helps practices provide comprehensive whole person care that acknowledges the behavioral health needs of the individual beyond the core requirements of NCQA PCMH Recognition. These practices have proven that they have the appropriate care team in place to manage the broad needs of patients with conditions related to behavioral health.

Approved Quote

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"Many times behavioral health conditions are first identified by a primary care provider," said Margaret E. O'Kane, NCQA President. "So adding behavioral health care services in a primary care setting is a real opportunity for patients. It knocks down barriers to behavioral care and improves overall health."

Patient-Centered Specialty Practice Recognition

Approved Language

- Practices that become recognized under Patient-Centered Specialty Practice Recognition have demonstrated commitment to patient-centered care and clinical quality through: streamlined referral processes and care coordination with referring clinicians, timely patient and caregiver-focused care management and continuous clinical quality improvement.

- Earning NCQA Patient-Centered Specialty Practice Recognition shows consumers, private payers and government agencies that the practice has undergone a rigorous review of its capabilities and is committed to sharing information and coordinating care. Recognition also signals to primary care practices that the specialty practice is ready to be an effective partner in caring for patients.

Approved Quote

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"NCQA Patient-Centered Specialty Practice Recognition distinguishes practices that communicate, collaborate and integrate care in ways that patients want and that improve quality," said NCQA President Margaret E. O'Kane. "I commend the team at [PRACTICE NAME] for its achievement, and for its commitment to continuous improvement."

Oncology Medical Home Recognition

Approved Language

- Practices that have earned NCQA Oncology Medical Home Recognition have undergone a rigorous review of its capabilities and have proven their commitment to delivering timely whole-person, evidence-based care. They have demonstrated their support of patients through timely patient and caregiver-focused care management and continuous quality improvement.

- Oncology Medical Home Recognized practices have demonstrated their ability to coordinate care with referring physicians during treatment and have put processes in place to foster relationships with patients which support an environment of communication and joint decision making, helping to improve the health and well-being of their patients.

- Recognized practices have improved patient access, making the scheduling of even same day appointments easier. Practices are better able to manage acute care helping patients avoid potential complications, ED visits and hospitalizations, allowing patients to spend more time at home.

- Oncology Medical Homes consistently monitor their performance and work to improve clinical outcomes, monitoring all aspects of a patient's health to positively impacting cancer patients care and reduce costs.

Approved Quote

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"NCQA Oncology Medical Home Recognition distinguishes practices that communicate, collaborate and integrate care in ways that patients want and that improve quality," said NCQA President, Margaret E. O'Kane. "I commend the team at [PRACTICE NAME] for its achievement, and for its commitment to continuous improvement."

School-Based Medical Home Recognition

Approved Language

- The School-Based Medical Home Recognition program is the first and only national program that recognizes school-based health centers providing full-spectrum care to children and adolescents in a safe and accessible location-their school.
- The School-Based Medical Home Recognition program is a hybrid model that evaluates how school-based health centers perform as a medical home, provide episodic care for students with urgent or emergent needs and act as a collaborative care center for students and the community served.
- School-based health centers seeking School-Based Medical Home Recognition demonstrate they meet NCQA PCMH requirements and complete the school-based health center subset of requirements in the same evaluation.

Approved Quote

The following pre-approved quotes may be used in your marketing and advertising materials. They may be used alone or in combination with other language. The quotes may not be modified or altered in any way. Any alternations or changes to the quotes must be submitted to NCQA for approval.

"The School-Based Medical Home program ensures high quality, coordinated school-based care for underserved children and adolescents who may have no other source of health care," said Patricia Barrett, Vice President, Product Design and Support. "We are proud of this new recognition program that provides the best standards of practice for our nation's youth in their schools, where they spend so much of their time."

How to Describe Your NCQA Status in a Press Release

All of the preceding rules apply to press releases. Organizations are welcome to create their own press releases mentioning their NCQA Recognition status. The press release must include a description of the recognition and the NCQA boiler plate:

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*NCQA is a private, nonprofit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations. It also recognizes clinicians and practices in key areas of performance. NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in health care. NCQA's website (**ncqa.org**) contains information to help consumers, employers and others make more-informed health care choices. NCQA can be found online at ncqa.org, on Twitter **@ncqa**, on Facebook at*

facebook.com/NCQA.org/ *and on LinkedIn at* ***linkedin.com/company/ncqa***.

Submit questions related to press releases through **My NCQA**.

Clinicians recognized under the PCMH Recognition program can download NCQA's press release template, personalize and distribute it to your local media. Please send the release to **communications@ncqa.org** for review and approval before distribution. If you would like NCQA to distribute a press release, please fill out the local media contacts form and e-mail it to **communications@nca.org**.

Compliance

It is the responsibility of the organization to follow and conform to all applicable NCQA Marketing and Advertising Guidelines. The information referencing your NCQA status or product must be accurate and not misleading. Only the organization that obtained the NCQA status can advertise such status and use the corresponding seal. The organizations' affiliates, including delegated entities, contractors and partners, are not allowed to use the NCQA status and seal. Failure to comply with these guidelines may jeopardize the organization's NCQA status.

In addition, NCQA will conduct periodic audits of customers' marketing and advertising materials at any time to ensure that marketing materials are true, not misleading, and that the organization's NCQA status is represented correctly. Failure to participate in the NCQA audit or refuse to comply with NCQA's request to address inaccuracies in information related to NCQA, NCQA status and/or product in your marketing and/or advertising materials constitutes a violation of NCQA's advertising guidelines and may result in, at NCQA's discretion, a revocation of an organization's NCQA status(es).

Organizations must maintain all copies of their marketing and advertising materials referencing NCQA status(es) and/or product(s) released or used in the past six months.

NCQA reserves the right to require an organization to withdraw their advertising materials from distribution immediately or to publish, at the organization's cost, a retraction and/or clarification in connection with any false or misleading statements or any violation of all applicable NCQA Marketing and Advertising Guidelines. Each organization agrees in advance to remedy such violation with the action deemed appropriate by NCQA.

Special Situations

NCQA realizes that these guidelines may not address all potential marketing and advertising materials. In such instances, organizations should contact the NCQA Marketing department through **My NCQA** to discuss the proposed marketing/advertising activity and associated marketing and/or advertising materials to achieve outcomes consistent with the spirit of these guidelines.

NCQA will respond to complaints regarding inaccurate and/or misleading advertising materials by our customers and their affiliates. Such complaints could initiate an audit of an organization's materials outside of the regular audit process.

PCMH Standards and Guidelines

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Team-Based Care and Practice Organization (TC)

The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.

Competency A: The Practice's Organization. The practice commits to transforming the practice into a sustainable patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure.

TC 01 (Core) PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.

GUIDANCE	EVIDENCE
The practice identifies the clinician lead *and* the transformation manager (the person leading the PCMH transformation). This may be the same person. Identification of the lead/manager includes: • Name. • Credentials. • Roles/responsibilities. Practice transformation is successful when there is support from a clinician lead. The lead's support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinical and operational support and resources to implement the PCMH model.	• **Details about the clinician lead** ***AND*** • **Details about the PCMH manager**

TC 02 (Core) Structure and Staff Responsibilities: Defines the practice's organizational structure and staff responsibilities/skills to support key PCMH functions.

GUIDANCE	EVIDENCE
The practice provides an overview of practice staff roles and an outline of duties staff will execute as part of the medical home, and explains how it will support and train staff to complete these duties. Structured tasks and stated staff responsibilities enable a practice to ensure that staff are providing efficient medical care and have training for the skills necessary to support the functions of the medical home.	• **Staff structure overview** ***AND*** • **Description of staff roles, skills and responsibilities**

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TC Competency A: Practice Organization.

TC 03 (1 Credit) External PCMH Collaborations: The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).

GUIDANCE	EVIDENCE
The practice demonstrates that it is involved in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state,; population-based care or learning collaborative. Participating in an ACO or clinically integrated network would not meet this requirement. Participating in ongoing collaboration with other practices or entities allows the practice's staff to learn and share best practices with their peers.	• **Description of involvement in external collaborative activity**

TC 04 (2 Credits) Patients/Families/Caregivers Involvement in Governance: Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.

GUIDANCE	EVIDENCE
The practice either: • Creates a role for patients/families/caregivers in the practice's governance structure or Board of Directors, ***or*** • Organizes a Patient and Family Advisory Council (PFAC) (stakeholder committee). The practices specifies: • How patients/families/caregivers are selected for participation. • The patient/family/caregivers' role. • Frequency of meetings. Patients are more than consumers in their care, they are partners. Involving patients/families/caregivers in the practice's governance can provide additional input to improve patient services and help engage patients in the care they receive from the practice.	• **Documented process** ***AND*** • **Evidence of implementation**

TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.

GUIDANCE	EVIDENCE
The practice enters the names of the electronic systems it implements. Only systems the practice is actively using should be entered. Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	• **CERHT name**

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Competency B: Team Communication. Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.

GUIDANCE	EVIDENCE
The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	• **Documented process** ***AND*** • **Evidence of implementation**  Documented process only

TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.

GUIDANCE	EVIDENCE
The practice describes staff roles and involvement in the performance evaluation and improvement activities. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team in review and evaluation of the practice's performance is important to identifying opportunities for improvement and developing meaningful improvement activities.	• **Documented process** ***AND*** • **Evidence of implementation** 

TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.

GUIDANCE	EVIDENCE
The practice identifies the behavioral healthcare manager and provides their qualifications. The care manager has the training to support behavioral health needs in the primary care office and coordinates referrals to specialty behavioral health services outside the practice. The practice demonstrates that it is working to provide meaningful behavioral health services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.	• **Identified behavioral healthcare manager** 

TC Competency C: Medical Home Responsibilities.

Competency C: Medical Home Responsibilities. The practice defines and communicates its role and the patient's role in the medical home model of care.

TC 09 (Core) Medical Home Information: Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.

GUIDANCE	EVIDENCE
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. At minimum, materials include: • Names and phone numbers of practice points of contact. • Instructions for reaching the practice after office hours. • A list of services offered by the practice. • How the practice uses evidence-based care. • A list of resources for patient education and self-management support. The practice explains to patients the importance of maintaining comprehensive information about their health care. It describes how and where (e.g., specialty practice, primary care office, ED) to access the care they need.	• **Documented process** ***AND*** • **Evidence of implementation**

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Knowing and Managing Your Patients (KM)

The practice captures and analyzes information about the patients and community it serves, and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

Competency A: Collecting Patient Information. The practice routinely collects comprehensive patient data and uses the data to understand patients' backgrounds and health risks.

KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.

GUIDANCE	EVIDENCE
Up-to-date means that the most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician, or by querying the patient—are added to the problem list. The report shows that the practice updates patients' problem lists at least annually. The patient's active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient's current care. Implementing KM 01 is a foundation for understanding health risks.	• **Report** ***OR*** • **KM 06—predominant conditions and health concerns**

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KM Competency A: Collecting Patient Information.

KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required):

A. Medical history of patient and family.
B. Mental health/substance use history of patient and family.
C. Family/social/cultural characteristics.
D. Communication needs.
E. Behaviors affecting health.
F. Social functioning.
G. Social determinants of health.
H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)
I. Advance care planning. (NA for pediatric practices.)

GUIDANCE	EVIDENCE
A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment. The practice uses evidence-based guidelines to determine how frequently the health assessments are completed and updated. Comprehensive, current data on patients provides a foundation for supporting population needs. As part of the comprehensive health assessment, the practice: **A. Medical history of patient and family.** Collects patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and "first-degree" relatives (who share about 50% of their genes with a specific family member). **B. Mental health/substance use history of patient and family.** Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression). **C. Family/social/cultural characteristics.** Evaluates social and cultural needs, preferences, strengths and limitations. Examples include family/household structure, support systems, and patient/family concerns. Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities). **D. Communication needs.** Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. ***Note:*** *This does not address language; refer to KM 10 for language needs.*	• **Documented process** ***AND*** • **Evidence of implementation** **PCMH PRIME** **B, E, H:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only.

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KM 02 (Core) Comprehensive Health Assessment (all items required): *continued*	
GUIDANCE	**EVIDENCE**
E. Behaviors affecting health. Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure. **F. Social functioning.** Assesses a patient's ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on. **G. Social determinants of health.** Collects information on **social determinants of health:** conditions in a patient's environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental **risk factors**; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). **H. Developmental screening using a standardized tool.** For newborns through 30 months, uses a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months. **I.** Documents patient/family preferences for **advance care planning** (care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation** **PCMH PRIME** **B, E, H:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only. 

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KM Competency A: Collecting Patient Information.

KM 03 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool.	
GUIDANCE	**EVIDENCE**
The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice reports the screening rate and identifies the standardized screening tool. **Screening for adults,** Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. **Screening for adolescents (12–18 years),** Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. In caring for the whole person, the medical home recognizes the impact depression can have on a patient's physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9) and acts on the results.	• **Documented process *or*** • **Report** ***AND*** • **Evidence of implementation** **PCMH PRIME** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation with an explanation.

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KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.)

A. Anxiety.
B. Alcohol use disorder.
C. Substance use disorder.
D. Pediatric behavioral health screening.
E. Post-traumatic stress disorder.
F. Attention deficit/hyperactivity disorder.
G. Postpartum depression.

GUIDANCE	EVIDENCE
Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Practice staff have been trained on the use of standardized tools to ensure accurate diagnosis, treatment and follow-up. A **standardized tool** collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The National Institute on Drug Abuse created a chart of Evidence Based Screening Tools for Adults and Adolescents for opioid screening, as well as alcohol and substance use tools. **A.** The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked to chronic medical conditions (e.g., heart disease, chronic pain disorders). **B.** The USPSTF recommends screening adults 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking; the Drug Abuse Screening Test (DAST); Cutting down, Annoyance by criticism, Guilty feeling and Eye-openers Questionnaire (CAGE); or another validated screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).	• **Documented process** ***AND*** • **Evidence of implementation** **PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only.

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KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
C. Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to address the patient's substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients' access to the necessary treatments toward sobriety. Available screening tools may include the CAGE AID or DAST-10 instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20). **D.** Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC). **E.** The practice uses standardized tools to determine if patients have developed post-traumatic stress disorder (PTSD). This condition develops in patients who have experienced a severe and distressing event. This event causes the patient to subsequently re-live the traumatic experience, causing mental distress. Assessments for PTSD support the practice in recognizing the ailment so it can either provide treatment or referrals to appropriate specialists. **F.** Attention deficit/hyperactivity disorder (ADHD) makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM V ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has ADHD. Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may and reduce its impact on patients/families/ caregivers.	• **Documented process** ***AND*** • **Evidence of implementation** **PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only. 

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KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
G. The USPSTF recommends screening of adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The USPSTF guidelines suggest screening during and after pregnancy. The AAP's Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-child care schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools, and may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits. For a list of screening tools, visit SAMHSA.gov, or for a list of pediatric screening tools, visit the American Academy of Pediatrics website. (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Primary-Care-Tools.aspx)	• **Documented process** ***AND*** • **Evidence of implementation** **PCMH PRIME** **A-C, G:** Practices in Massachusetts interested in credit toward PCMH PRIME Certification must also submit a system-generated report with a numerator and denominator based on all unique patients in a recent 3-month period. A practice that does not have the electronic capability to generate this report may submit a documented process and evidence of implementation only. 
KM 05 (1 Credit) Oral Health Assessment and Services: Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	
GUIDANCE	**EVIDENCE**
The practice conducts patient-specific oral health risk assessments and keeps a list of oral health partners such as dentists, endodontists, oral surgeons and/or periodontists from which to refer. Poor oral health can have a significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions (e.g., fluoride application for pediatric patients) and timely referrals.	• **Documented process** ***AND*** • **Evidence of implementation** 

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KM Competency A: Collecting Patient Information.

KM 06 (1 Credit) Predominant Conditions and Concerns: Identifies the predominant conditions and health concerns of the patient population.

GUIDANCE	EVIDENCE
The practice analyzes diagnosis codes or problem lists to identify its patients' most prevalent and important conditions and concerns. Although the general conditions treated in primary care are similar across practices, each medical home has a unique population that influences how the practice organizes work and resources. Knowing its population's top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialties to establish clear referral relationships and determine what special services to offer (e.g., group sessions, education, counseling).	• **List of top priority conditions and concerns** 

KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.

GUIDANCE	EVIDENCE
After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population. Routine collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs.	• **Report** ***AND*** • **Evidence of implementation**

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KM 08 (1 Credit) Patient Materials: Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.	
GUIDANCE	**EVIDENCE**
The practice demonstrates an understanding of the patients' communication needs by utilizing materials and media that are easy for their patient population to understand and use. The practice considers patient demographics such as age, language needs, ethnicity and education when creating materials for its population. The practice may consider how its patients like to receive information (i.e., paper brochure, phone app, text message, email), in addition to the readability of materials (e.g., general literacy and health literacy). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and establish processes that address health literacy to improve patient health behaviors and safety in the practice setting. Reducing barriers to the patient's ability to access, understand and absorb health information supports their ability to comply with their care.	• **Report** ***AND*** • **Evidence of implementation** 

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KM Competency B: Patient Diversity.

Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.

KM 09 (Core) Diversity: Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.	
GUIDANCE	**EVIDENCE**
The practice collects information on how patients identify in at least three areas that include: 1. Race. 2. Ethnicity. 3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence. Assessing the diversity of its population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers, leading to disparities in health outcomes. The practice may collect data directly from patients or may use data about the community (e.g., zip code analysis, community level census data) it serves.	• **Report**
KM 10 (Core) Language: Assesses the language needs of its population.	
GUIDANCE	**EVIDENCE**
The practice identifies the prevalent language needs of its population. It may collect data directly from all patients or from community-level statistics for the community it serves. If the practice collects data directly, all responses (e.g., patient declined to provide language information, primary language is English, patient does not need language services) must be recorded; a blank field does not mean the patient's preferred language is English. Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively (e.g., materials in prevalent languages, translation services, bilingual staff).	• **Report**

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KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):

A. Targets population health management on disparities in care.

B. Educates practice staff on health literacy.

C. Educates practice staff in cultural competence.

GUIDANCE	EVIDENCE
The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs. The practice: **A.** Identifies disparities in care and implements actions to reduce the disparity. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. **B.** Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes. **C.** Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients. **Health literacy resources** • Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf • Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit: http://www.ahrq.gov/professionals/ quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf • Alliance for Health Reform Toolkit: http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf	• **A: Evidence of implementation** ***OR*** • **A: QI 05 *and*** • **A: QI 13** • **B: Evidence of implementation** • **C: Evidence of implementation** 

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KM Competency C: Addressing Patient Needs.

Competency C: Addressing Patient Needs. The practice proactively addresses the care needs of the patient population to ensure needs are met.

KM 12 (Core) Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):

A. Preventive care services.

B. Immunizations.

C. Chronic or acute care services.

D. Patients not recently seen by the practice.

GUIDANCE	EVIDENCE
The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients, the practice addresses a variety of health care needs using evidence-based guidelines, including missing recommended follow-up visits. The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services.	• **A, B, D: Report/list *and*** • **A, B, D: Outreach materials** • **C: Report/list *and*** • **C: Outreach materials** ***OR*** • **C: KM 13**

KM 13 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.

GUIDANCE	EVIDENCE
At least 75 percent of eligible clinicians have earned NCQA HSRP or DRP Recognition. Alternatively, the practice demonstrates that it is participating in a program that uses a common set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages. Examples of programs may include MN Community Measures, Bridges to Excellence, IHA or other performance-based recognition programs.	• **Report** ***OR*** • **HSRP or DRP recognition for at least 75% of eligible clinicians**

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KM Competency D: Medication Management.

Competency D: Medication Management. The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.

KM 14 (Core) Medication Reconciliation: Reviews and reconciles medications for more than 80 percent of patients received from care transitions.	
GUIDANCE	**EVIDENCE**
The practice reviews all prescribed medications a patient is taking and documents this in the medical record. Conflicts or potential discrepancies in medications are identified and addressed by clinical staff. Medication review and reconciliation occurs at transitions of care, or at least annually. Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients received from care transitions, because they are more likely to be elderly, use multiple pharmacies, multiple providers and have co-morbid conditions. **Medication reconciliation** is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addresses any potential conflicts including name, dosage, frequency and drug-drug interactions.	• **Report**

KM 15 (Core) Medication Lists: Maintains an up-to-date list of medications for more than 80 percent of patients.	
GUIDANCE	**EVIDENCE**
The practice routinely collects information from patients about medications they take and keeps up-to-date lists of patients' medications. Medication data should be captured in searchable fields. The list should include the date when it was last updated, prescription and nonprescription medications, over-the-counter medications and herbal and vitamin/ mineral/dietary (nutritional) supplements.	• **Report**

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KM Competency D: Medication Management.

KM 16 (1 Credit) New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.

GUIDANCE	EVIDENCE
The practice uses patient-centered methods, such as open-ended questions (teach-back collaborative method), to assess patient understanding of new medications prescribed by the specialist. Educational materials are designed with regard to patient need (e.g., reading level). Medication is not taken as prescribed 50 percent of the time. (Source: CDC) Barriers to adherence, such as not understanding directions and confusion amongst multiple medication regimens, lead to poorer health outcomes and compromise patient safety.	• **Report** ***AND*** • **Evidence of implementation**

KM 17 (1 Credit) Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.

GUIDANCE	EVIDENCE
The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed. If a patient is not taking a medication as prescribed, the practice determines why. Patients cannot get the full benefits of their medications if they do not take them as prescribed.	• **Report** ***AND*** • **Evidence of implementation**

KM 18 (1 Credit) Controlled Substance Database Review: Reviews a controlled substance database when prescribing relevant medications.

GUIDANCE	EVIDENCE
The practice consults a state controlled-substance database—also known as a Prescription Drug Monitoring Program (PDMP) or Prescription Monitoring Program (PMP)—before dispensing Schedule II, III, IV and V controlled substances. The practice follows established guidelines or state requirements to determine frequency of review. This can prevent overdoses and misuse, and can support referrals for pain management and substance use disorders. For a list of PDMPs by state: http://www.pdmpassist.org/content/state-pdmp-websites	• **Evidence of implementation** 

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KM Competency D: Medication Management.

KM 19 (2 Credits) Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.	
GUIDANCE	**EVIDENCE**
The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as SureScripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies. The practice uses prescription claims data to determine whether a patient is adhering to the medication treatment plan.	• **Evidence of implementation**

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KM Competency E: Evidence-Based Care.

Competency E: Evidence-Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.

KM 20 (Core) Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria):

A. A mental health condition.
B. A substance use disorder.
C. A chronic medical condition.
D. An acute condition.
E. A condition related to unhealthy behaviors.
F. Well-child or adult care.
G. Overuse/appropriateness issues.

GUIDANCE	EVIDENCE
The practice utilizes systems in its day-to-day operations that integrate evidence-based guidelines (frequently referred to as clinical decision support [CDS]). **CDS** is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care. CDS encompasses a variety of tools, including, but not limited to: • Computerized alerts and reminders for providers and patients. • Condition-specific order sets. • Focused patient data reports and summaries. • Documentation templates. • Diagnostic support. • Contextually relevant reference information. Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS. **A. Mental health.** The practice uses evidence-based guidelines to support clinical decisions related to at least one mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer's) in the care of patients. **B. Substance use disorder treatment.** The practice uses evidence-based guidelines to support clinical decisions related to at least one substance misuse issue (e.g., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM 20 (Core) Clinical Decision Support: *continued*	
GUIDANCE	**EVIDENCE**
C. A chronic medical condition. The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition (e.g., arthritis, asthma, cardiovascular disease, COPD, diabetes) in the care of patients. **D. An acute condition.** The practice uses evidence-based guidelines to support clinical decisions related to at least one acute medical condition (e.g., acute back pain, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis, urinary tract infection) in the care of patients. **E. A condition related to unhealthy behaviors.** The practice uses evidence-based guidelines to support clinical decisions related to at least one unhealthy behavior (e.g., obesity, smoking) in the care of patients. **F. Well child or adult care.** The practice uses evidence-based guidelines to support clinical decisions related to well-child or adult care (e.g., age appropriate screenings, immunizations) in the care of patients. **G. Overuse/appropriateness issues.** The practice uses evidence-based guidelines to support clinical decisions related to overuse or appropriateness of care issues (e.g., use of antibiotics, avoiding unnecessary testing, referrals to multiple specialists) in the care of patients. The American Board of Internal Medicine Foundation's Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support (http://www.choosingwisely.org).	• **Identifies conditions, source of guidelines** ***AND*** • **Evidence of implementation**

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KM Competency F: Connecting With Community Resources.

Competency F: Connecting With Community Resources. The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

KM 21 (Core) Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources.	
GUIDANCE	**EVIDENCE**
The practice identifies needed resources by assessing collected population information. It may assess social determinants, predominant conditions, ED use and other health concerns to prioritize community resources (e.g., food banks, support groups) that support the patient population.	• **List of key patient needs and concerns** 
KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	
GUIDANCE	**EVIDENCE**
Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients. • **Educational programs and resources** may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups). • **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings. The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate patients to interact with and learn from each other.	• **Evidence of implementation** 

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KM Competency F: Connecting With Community Resources.

KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.	
GUIDANCE	**EVIDENCE**
The practice provides an example of how it provides educational and other resources to patients pertaining to oral health and hygiene. Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease.	• **Evidence of implementation**

KM 24 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	**EVIDENCE**
The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another. The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Helping patients understand their health condition and engaging them in shared decision making helps build a trusting relationship. **Shared decision-making resources** • International Patient Decision Aid Standards Collaboration (IPDASC) http://ipdas.ohri.ca/index.html • AHRQ's SHARE Approach https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html	• **Evidence of implementation**

KM 25 (1 Credit) School/Intervention Agency Engagement: Engages with schools or intervention agencies in the community.	
GUIDANCE	**EVIDENCE**
The practice develops supportive partnerships with social services organizations or schools in the community. The practice demonstrates this through formal or informal agreements or identifies practice activities in which community entities are engaged to support better health.	• **Documented Process** ***AND*** • **Evidence of implementation**

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KM Competency F: Connecting With Community Resources.

KM 26 (1 Credit) Community Resource List: Routinely maintains a current community resource list based on the needs identified in KM 21.

GUIDANCE	EVIDENCE
The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates, and an update/maintenance date to demonstrate that the list is regularly updated. Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to community resources that support their health and well-being from that additional support.	• **List of resources**

KM 27 (1 Credit) Community Resource Assessment: Assesses the usefulness of identified community support resources.

GUIDANCE	EVIDENCE
The practice assesses the usefulness of resources by requesting and reviewing feedback from patients/ families/caregivers about community referrals. Community referrals differ from clinical referrals, but may be tracked using the same system. When a practice's patients have unmet social needs, the practice can refer patients to useful community support resources. Meeting the patient's social needs supports self-management and reduces barriers to care.	• **Evidence of implementation**

KM 28 (2 Credits) Case Conferences: Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).

GUIDANCE	EVIDENCE
The practice uses "case conferences" to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team. **Case conferences** are planned, multidisciplinary meetings with community organizations or specialists to plan treatment for complex patients.	• **Documented process** ***AND*** • **Evidence of implementation**

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Patient-Centered Access and Continuity (AC)

The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

Competency A: Patient Access to the Practice. The practice enhances patient access by providing appointments and clinical advice based on patients' needs.

AC 01 (Core) Access Needs and Preferences: Assesses the access needs and preferences of the patient population.

GUIDANCE	EVIDENCE
The practice evaluates patient access from collected data (i.e., survey, patient interviews, comment box) to determine if existing access methods are sufficient for its population. Alternative methods for access may include evening/weekend hours, types of appointments or telephone advice.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

AC 02 (Core) Same-Day Appointments: Provides same-day appointments for routine and urgent care to meet identified patient needs.

GUIDANCE	EVIDENCE
The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine and for urgent care needs. The time frames allocated for these appointment types are determined by the practice and based on the needs of the patient population, as defined in AC 01. Evidence may include: • A 5-day schedule to demonstrate that appointments are available. • A report demonstrating that same-day appointments were used. • Significant patient-reported satisfaction with access, based on AC 01 data.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

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AC 03 (Core) Appointments Outside Business Hours: Provides routine and urgent appointments outside regular business hours to meet identified patient needs.	
GUIDANCE	**EVIDENCE**
The practice recognizes that patients' care needs are not confined to normal operating hours, and therefore offers routine and urgent care appointments outside typical business hours. For example, a practice may open for appointments at 7 a.m. or remain open until 8 p.m. on certain days or open on alternating Saturdays. A documented process is not required if extended hours are provided at the practice site. A practice that cannot provide care outside regular business hours (e.g., a small practice with limited staffing) may arrange for patients to schedule appointments with other facilities or clinicians. The practice may use an urgent care center in the same health system for urgent and routine appointments outside regular business hours, or an urgent care center in the community that has access to patient records. Providing extended access does not include: • Offering appointments when the practice would otherwise be closed for lunch. • Offering daytime appointments when the practice would otherwise close early (e.g., a Friday afternoon or holiday). • Utilizing an ED or urgent care facility that is unaffiliated with the practice.	• **Documented process** ***AND*** • **Evidence of implementation**

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AC 04 (Core) Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.	
GUIDANCE	**EVIDENCE**
Patients can telephone the practice any time of the day or night and receive interactive (from a person, rather than a recorded message) clinical advice. **Clinical advice** refers to a response to an inquiry regarding symptoms, health status or an acute/ chronic condition. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7 days of such calls.	• **Documented process** ***AND*** • **Report**

AC 05 (Core) Clinical Advice Documentation: Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient's medical record.	
GUIDANCE	**EVIDENCE**
The practice documents all clinical advice in the patient record, whether it is provided by phone or by secure electronic message. Evidence includes two examples of documenting clinical advice (one during office hours and one after normal business hours as defined in AC 03). If a practice uses a system of documentation outside the medical record for after-hours clinical advice, or provides after-hours care without access to the patient's record, it reconciles this information with the medical record on the next business day. The reconciliation evaluates if clinical advice or care provided after hours conflicts with advice and care needs previously documented in the medical record, and addresses any identified conflicts.	• **Documented process** ***AND*** • **Evidence of implementation**

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AC Competency A: Patient Access to the Practice.

AC 06 (1 Credit) Alternative Appointments: Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.

GUIDANCE	EVIDENCE
The practice uses a mode of real-time communication (e.g., a combination of telephone, video chat, secure instant messaging) in place of a traditional in-person office visit with a clinician or care manager. The practice provides a report of the number and types of visits in a specified time period. These types of visits do not meet the requirement: • Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, website) during office hours. • An appointment with an alternative type of clinician (e.g., diabetic counselor).	• **Documented process** ***AND*** • **Report**  ***Documented process only***

AC 07 (1 Credit) Electronic Patient Requests: Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.

GUIDANCE	EVIDENCE
Patients can use a secure electronic system (e.g., website, patient portal, email) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least two functionalities or provide patients with guidelines for at least two types of these requests that can be made electronically. Electronic patient requests are another means to patients' access to services that meet their needs and preferences.	• **Evidence of implementation** 

AC 08 (1 Credit) Two-Way Electronic Communication: Has a secure electronic system for two-way communication to provide timely clinical advice.

GUIDANCE	EVIDENCE
The practice has a secure, interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication between the practice and patients/families/ caregivers, as applicable for the patient. The practice can send messages to and receive messages from patients. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7 days of such activity. The report may be system generated. The practice defines the time frame for a response and monitors the timeliness of responses against the time frame.	• **Documented process** ***AND*** • **Report** 

AC 09 (1 Credit) Equity of Access: Uses information about the population served by the practice to assess equity of access that considers health disparities.	
GUIDANCE	**EVIDENCE**
Knowing whether groups of patients experience differences in access to health care can help practices focus efforts to address the inequity. The practice evaluates whether identified health disparities demonstrate differences in access to care. An example of how a practice may demonstrate this is through a report of how an identified group of patients has lower rates of access to same-day appointments, higher no-show rates, more ED use or lower satisfaction with access than the general patient population. Healthy People 2020 defines **health disparity** as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."	• **Evidence of implementation**

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AC Competency B: Empanelment and Access to the Medical Record.

Competency B: Empanelment and Access to the Medical Record. Practices support continuity through empanelment and systematic access to the patient's medical record.

AC 10 (Core) Personal Clinician Selection: Helps patients/families/ caregivers select or change a personal clinician.	
GUIDANCE	**EVIDENCE**
Giving patients/families/caregivers a choice of clinician emphasizes the importance of the ongoing patient-clinician relationship. The practice documents patients' choice of clinician, gives patients/families/caregivers information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice may document a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a **practice team.** Single-clinician sites automatically meet this criterion.	• **Documented process** 
AC 11 (Core) Patient Visits with Clinician/Team: Sets goals and monitors the percentage of patient visits with the selected clinician or team.	
GUIDANCE	**EVIDENCE**
The practice establishes a goal for the proportion of visits a patient should have with the primary care provider and care team. The goal should acknowledge that meeting patient preferences for timely appointments will sometimes be at odds with the ability to see their selected clinician. **Empanelment** is assigning individual patients to individual primary care providers and care teams, with sensitivity to patient and family preferences. It is the basis for population health management and the key to continuity of care: Patients can build a better relationship with a clinician or team they see regularly.	• **Report**
AC 12 (2 Credits) Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.	
GUIDANCE	**EVIDENCE**
The practice makes patient clinical information available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed. Access to medical records may include direct access to a paper or electronic record or arranging a telephone consultation with a clinician who has access to the medical record.	• **Documented process** 

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AC Competency B: Empanelment and Access to the Medical Record.

AC 13 (1 Credit) Panel Size Review and Management: Reviews and actively manages panel sizes.	
GUIDANCE	**EVIDENCE**
The practice has a process to review the number of patients assigned to each clinician and balance the size of each providers' patient panel. Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and provider workload because supply is balanced with patient demand. The American Academy of Family Physicians provides a tool for practices to use when considering and managing panel sizes: http://www.aafp.org/fpm/2007/0400/p44.pdf	• **Documented process** ***AND*** • **Report**  ***Documented process only***

AC 14 (1 Credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments.	
GUIDANCE	**EVIDENCE**
The practice receives reports from outside entities such as health plans, ACOs and Medicaid agencies on the patients that are attributed to each clinician. The practice has a process to review the reports and a process to inform those entities of the patients known or not known to be under the care of each clinician. Reconciling panels with health plans and other entities improves accountability, continuity and access.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

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Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Competency A: Identifying Care Managed Patients. The practice systematically identifies patients who may benefit from care management.

CM 01 (Core) Identifying Patients for Care Management: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):

A. Behavioral health conditions.
B. High cost/high utilization.
C. Poorly controlled or complex conditions.
D. Social determinants of health.
E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

GUIDANCE	EVIDENCE
The practice defines a protocol to identify patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A–E. Examples include, but are not limited to: **A.** Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment. **B.** Patients who experience multiple ER visits, hospital readmissions, high total cost of care, unusually high numbers of imaging or lab tests ordered, unusually high number of prescriptions, high-cost medications and number of secondary specialist referrals. **C.** Patients with poorly controlled or complex conditions such as, continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions. **D.** Availability of resources such as food and transportation to meet daily needs; access to educational, economic and job opportunities; public safety; social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). **E.** Direct identification of patients who might need care management, such as referrals by health plans, practice staff, patient, family members or caregivers.	• **Protocol for identifying patients for care management** ***OR*** • **CM 03**

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CM Competency A: Identifying Care Managed Patients.

CM 02 (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.	
GUIDANCE	**EVIDENCE**
The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. The practice uses the criteria defined in CM 01 to identify patients who fit defined criteria. The practice must identify at least 30 patients in the numerator. Patients who fit multiple criteria count once in the numerator. Small practices or satellite sites may share a care management population if fewer than 30 patients meet the criteria defined in CM 01.	• **Report**
CM 03 (2 Credits) Comprehensive Risk-Stratification Process: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. The practice identifies and directs resources appropriately based on need. **Risk-stratification resources** • American Academy of Family Physicians' Risk Stratified Care Management Rubric. • CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model.	• **Report** 

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CM Competency B: Care Plan Development.

Competency B: Care Plan Development. For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.

CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice has a process for consistent development of care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/lifestyle goals, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**  ***Patient examples only***

CM 05 (Core) Written Care Plans: Provides a written care plan to the patient/family/caregiver for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice provides the patient's written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient's health literacy and language preferences. (the patient version may use different words or formats from the version used by the practice team). The care plan may be printed and given to the patient or made available electronically.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**  ***Patient examples only***

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CM Competency B: Care Plan Development.

CM 06 (1 Credit) Patient Preferences and Goals: Documents patient preference and functional/lifestyle goals in individual care plans.

GUIDANCE	EVIDENCE
The practice works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. Including patient preferences and goals encourages a collaborative partnership between patient/family/caregiver and provider, and ensures that patients are active participants in their care. **Functional/lifestyle goals** can be individually meaningful activities that a person wants to be able to perform but may be at risk due to a health condition or treatment plan. Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**  ***Patient examples only***

CM 07 (1 Credit) Patient Barriers to Goals: Identifies and discusses potential barriers to meeting goals in individual care plans.

GUIDANCE	EVIDENCE
Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may include physical, emotional or social barriers. The practice works with patients/families/caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/ lifestyle goals.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**  ***Patient examples only***

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CM Competency B: Care Plan Development.

CM 08 (1 Credit) Self-Management Plans: Includes a self-management plan in individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan. Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers to meeting care-plan goals.	• **Report** ***OR*** • **Record Review Workbook *and*** • **Patient examples**  ***Patient examples only***
CM 09 (1 Credit) Care Plan Integration: Care plan is integrated and accessible across settings of care.	
GUIDANCE	**EVIDENCE**
Sharing the care plan supports its implementation across all settings that address the patient's care needs. The practice makes the care plan accessible across external care settings. It may be integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.	• **Documented process** ***AND*** • **Evidence of implementation** 

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Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

Competency A: Diagnostic Test Tracking and Follow-Up. The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.

CC 01 (Core) Lab and Imaging Test Management: The practice systematically manages lab and imaging tests by:

A. Tracking lab tests until results are available, flagging and following up on overdue results.
B. Tracking imaging tests until results are available, flagging and following up on overdue results.
C. Flagging abnormal lab results, bringing them to the attention of the clinician.
D. Flagging abnormal imaging results, bringing them to the attention of the clinician.
E. Notifying patients/families/caregivers of normal lab and imaging test results.
F. Notifying patients/families/caregivers of abnormal lab and imaging test results.

GUIDANCE	EVIDENCE
The practice demonstrates how it manages patient tests and test results (report, log, examples or electronic tracking system). If frequent lab tests are ordered for a patient, the practice provides the patient/family/caregiver (as appropriate) with all initial results, clear expectations for follow-up results and a plan for handling abnormal findings. Ineffective management of laboratory and imaging test results can result in less than optimal care, excess costs, and may compromise patient safety. Systematic monitoring helps ensure that needed tests are performed and that results are acted on, when necessary. **A, B.** The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system with a timely surveillance process. The practice follows up with the lab or diagnostic center (and the patient, if necessary) to determine why results are overdue, and documents follow-up efforts until reports are received. **C, D.** Abnormal results of lab or imaging tests are flagged and brought to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver. **E, F.** The practice provides timely notification to patients about test results (normal and abnormal). Filing in results in the medical record for discussion during a scheduled office visit does not meet the requirement.	• **Documented process** ***AND*** • **Evidence of implementation**

CC Competency A: Diagnostic Test Tracking and Follow-Up.

CC 02 (1 Credit) Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.	
GUIDANCE	**EVIDENCE**
The practice follows up with the hospital or state health department if it does not receive screening results. Most states mandate that birthing facilities perform a blood-spot test to screen for congenital conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. Early detection and treatment of congenital disorders can enhance health outcomes for newborns with positive (abnormal) screening results. Practices that do not see newborn patients are not eligible for this elective criterion.	• **Documented process** ***AND*** • **Evidence of implementation** 

CC 03 (2 Credits) Appropriate Use for Labs and Imaging: Uses clinical protocols to determine when imaging and lab tests are necessary.	
GUIDANCE	**EVIDENCE**
The practice establishes clinical protocols based on evidence-based guidelines, to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in the order entry system). Inappropriate use of imaging or lab tests leads to unnecessary costs and risks and does not enhance patient outcomes.	• **Evidence of implementation** 

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CC Competency B: Referrals to Specialists.

Competency B: Referrals to Specialists. The practice provides important information in referrals to specialists and tracks referrals until the report is received.

CC 04 (Core) Referral Management: The practice systematically manages referrals by:

A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.

B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.

C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services, as well as frustration for providers. Referrals may be tracked by the practice using a log or electronic system are determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect). **A.** The referring clinician provides a reason for the referral, which may be stated as the **clinical question** to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition; or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent appointment. **B.** Referrals include relevant clinical information such as: • Current medications. • Diagnoses, including mental health, allergies, medical and family history, substance abuse and behaviors affecting health.	• **Documented process** ***AND*** • **Evidence of implementation**

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CC Competency B: Referrals to Specialists.

CC 04 (Core) Referral Management: *continued*	
GUIDANCE	**EVIDENCE**
• Clinical findings and current treatment. • Follow-up communication or information. Including the referring primary care clinician's care and treatment plan in the referral, in addition to test results and procedures, can reduce conflicts and duplicate services, tests and treatment. If the practice sends the primary care plan with the referral, the specialist can develop a corresponding specialty plan of care. Ideally, the primary care plan, developed in collaboration with the patient/family/caregiver, is coordinated with the specialty plan of care, created in collaboration with the patient/family/caregiver and primary care. **C.** A tracking process includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the specialist's office and documents its effort to retrieve the report in a log or an electronic system.	• **Documented process** ***AND*** • **Evidence of implementation** 
CC 05 (2 Credits) Appropriate Referrals: Uses clinical protocols to determine when a referral to a specialist is necessary.	
GUIDANCE	**EVIDENCE**
The practice uses clinical protocols or decision-support tools to determine if a patient needs to be seen by a specialist or if care can be addressed or managed by the primary care clinician. Unnecessary referrals can lead to overuse of tests and services, increase patient dissatisfaction and reduce accessibility to specialists when needed.	• **Evidence of implementation** 

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CC Competency B: Referrals to Specialists.

CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.

GUIDANCE	EVIDENCE
The practice monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently. This information may help identify areas where the practice can adopt guidelines or protocols to manage patient care in the primary care practice and identify trends in the patient population, and can help identify opportunities for improved coordination and patient experience when specialty care is needed.	• **Evidence of implementation**

CC 07 (2 Credits) Performance Information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals.

GUIDANCE	EVIDENCE
It is important for the practice to make informed referrals to clinicians or practices that will provide timely, high-quality care. The practice consults available information about the performance of clinicians or practices to which it refers patients. The practice provides information or examples of the available performance data on the consultant/ specialist with the practice team. Information gathered in CC 11 may be useful in assessing consultants/specialists.	• **Data source** ***AND*** • **Examples** 

CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.

GUIDANCE	EVIDENCE
Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	• **Documented process** ***OR*** • **Agreement** 

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CC Competency B: Referrals to Specialists.

CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.	
GUIDANCE	**EVIDENCE**
Relationships between primary care practitioners and specialists support consistency of information shared across practices. The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A notification demonstrating legal inability to receive a report that includes confirmation a behavioral health visit occurred meets the content requirement. A practice needs an agreement if it shares the same facility or campus as behavioral healthcare professionals but has separate systems (basic onsite collaboration). The practice may present existing internal processes if there is partial integration of behavioral healthcare services.	• **Agreement** ***OR*** • **Documented process *and*** • ***E*vidence of implementation** 

CC 10 (2 Credits) Behavioral Health Integration: Integrates behavioral healthcare providers into the care delivery system of the practice site.	
GUIDANCE	**EVIDENCE**
Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies.	• **Documented process** ***AND*** • **Evidence of implementation** 

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CC Competency B: Referrals to Specialists.

CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.	
GUIDANCE	**EVIDENCE**
The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan. The practice bases its definition of "timely" on patient need. Ongoing assessment and referral monitoring may be helpful in CC 07.	• **Documented process** ***AND*** • **Report**  ***Documented process only***
CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the patient's medical record.	
GUIDANCE	**EVIDENCE**
When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co-management of the patient's care. Under the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame. The practice must provide three examples of such arrangements.	• **Evidence of implementation**
CC 13 (2 Credits) Treatment Options and Costs: Engages with patients regarding cost implications of treatment options.	
GUIDANCE	**EVIDENCE**
Cost can play a major role in a patient's drug and treatment adherence; the practice understands this and talks to patients about treatment costs (e.g., adds a financial question to the clinical intake screening [do you have trouble affording the care or prescriptions prescribed? Y/N], directs patients to resources such as copay and prescription assistance programs; the clinician asks about prescription drug coverage, tells patients which services are critical and should not be skipped, recommends less expensive options, if appropriate).	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

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CC Competency C: Coordinating Care With Health Care Facilities.

Competency C: Coordinating Care With Health Care Facilities. The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

CC 14 (Core) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.

GUIDANCE	EVIDENCE
The practice has a process for monitoring unplanned admissions and ED visits, including their frequency. The practice works with local hospitals, EDs and health plans to identify patients with recent unplanned visits, and demonstrates how it systematically receives notifications from facilities with which the practice has established mechanisms for exchange.	• **Documented process** ***AND*** • **Evidence of implementation**

CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.

GUIDANCE	EVIDENCE
The practice demonstrates timely sharing of information with admitting hospitals and EDs. The practice provides three examples as evidence of implementation. Shared information supports continuity in patient care across settings.	• **Documented process** ***AND*** • **Evidence of implementation**

CC 16 (Core) Post-Hospital/ED visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

GUIDANCE	EVIDENCE
The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice's policies define the appropriate contact period and systematically documents follow-up. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encourage follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs.	• **Documented process** ***AND*** • **Evidence of implementation**

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CC Competency C: Coordinating Care With Health Care Facilities.

CC 17 (1 Credit) Acute Care After Hours Coordination: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.

GUIDANCE	EVIDENCE
The practice has a process to coordinate with acute care facilities when a patient is seen after the office is closed. Sharing patient information allows the facility to coordinate patient care based on current health needs and engage with practice staff.	• **Documented process** ***AND*** • **Evidence of implementation**  ***Documented process only***

CC 18 (1 Credit) Information Exchange during Hospitalization: Exchanges patient information with the hospital during a patient's hospitalization.

GUIDANCE	EVIDENCE
The practice demonstrates that it can send and receive patient information during a patient's hospitalization. ***Note:*** *CC 15 assesses the practice's ability to share information, but the focus of CC 18 is two-way exchange of information.*	• **Documented process** ***AND*** • **Evidence of implementation** 

CC 19 (1 Credit) Patient Discharge Summaries: Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.

GUIDANCE	EVIDENCE
The practice has a process for obtaining patient discharge summaries for patients following discharge from a hospital or other care facility. The practice shows that it obtains discharge summaries directly or demonstrates participation in a local admission, discharge, transfer (ADT) system. Actively gathering information about patient admissions, discharges or transfers from the hospital and other care facilities improves care coordination, safe handoffs and reduces readmissions.	• **Documented process** ***AND*** • **Evidence of implementation** 

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CC Competency C: Coordinating Care With Health Care Facilities.

CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions: Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).	
GUIDANCE	**EVIDENCE**
The practice involves the patient/family/caregiver in the development or implementation of a written care plan for young adults and adolescent patients with complex needs transitioning to adult care. The written care plan may include: • A summary of medical information (e.g., history of hospitalizations, procedures, tests). • A list of providers, medical equipment and medications for patients with special health care needs. • Obstacles to transitioning to an adult care clinician. • Special care needs. • Information provided to the patient about the transition of care. • Arrangements for release and transfer of medical records to the adult care clinician. • Patient response to the transition. • Patient transition plan. **Internal medicine practices** receiving patients from pediatricians are expected to request/review the transition plan provided by pediatric practices, or to develop a plan, if one is not provided, to support a smooth and safe transition. **For family medicine practices** that do not transition patients from pediatric to adult care, should still educate patients and families about ways in which their care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.	• **Evidence of implementation**

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CC Competency C: Coordinating Care With Health Care Facilities.

CC 21 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (may select one or more):

A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit)

B. Immunization registries or immunization information systems. (1 Credit)

C. Summary of care record to another provider or care facility for care transitions. (1 Credit)

GUIDANCE	EVIDENCE
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this electronic exchange by: **A.** Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. **B.** Submitting electronic data to immunization registries, to share immunization services provided to patients. **C.** Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each criterion, for up to three credits. Each option is part of CC 21, but is listed separately in Q-PASS for scoring purposes.	• **Evidence of implementation**

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Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Competency A: Measuring Performance. The practice measures to understand current performance and to identify opportunities for improvement.

QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

A. Immunization measures.
B. Other preventive care measures.
C. Chronic or acute care clinical measures.
D. Behavioral health measures.

GUIDANCE	EVIDENCE
Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least: • One immunization measure. • One preventive care measure (not including immunizations). – A measure on oral health counts as a preventive clinical quality measure. • One chronic or acute care clinical measure. • One behavioral health measure. The data must include the measurement period, the number of patients represented by the data, the rate and the measure source (e.g. HEDIS, NQF #, measure guidance).	• **Report**

QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource stewardship (must monitor at least one measure of each type):

A. Measures related to care coordination.
B. Measures affecting health care costs.

GUIDANCE	EVIDENCE
The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination. When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources.	• **Report**

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QI Competency A: Measuring Performance.

QI 03 (Core) Appointment Availability Assessment: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.

GUIDANCE	EVIDENCE
Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources). A common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type.	• **Documented process** ***AND*** • **Report**  ***Documented process only***

QI 04 (Core) Patient Experience Feedback: Monitors patient experience through:

A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as:
- Access.
- Communication.
- Coordination.
- Whole-person care, self-management support and comprehensiveness.

B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.

GUIDANCE	EVIDENCE
The practice gathers feedback from patients and provides summarized results to inform quality improvement activities. Patient feedback must represent the practice population (including all relevant subpopulations) and may not be limited to patients of one clinician (of several), or to data from one payer (of several). **A.** The practice (directly or through a survey vendor) conducts a patient survey to assess the patient/family/caregiver experience with the practice. The patient survey may be conducted as a written questionnaire (paper or electronic) or by telephone, and includes questions related to at least three of the following categories: • **Access** (may include routine, urgent and after-hours care). • **Communication with the practice, clinicians and staff** (may include "feeling respected and listened to" and "able to get answers to questions").	• **Report**

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QI Competency A: Measuring Performance.

QI 04 (Core) Patient Experience Feedback: *continued*	
GUIDANCE	**EVIDENCE**
• **Coordination of care** (may include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results). • **Whole-person care/self-management support** (may include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, routine and urgent care, advice, assistance and support for changing health habits and making health care decisions). **B.** Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as "virtual" (e.g., telephone, videoconference) participation. Comments collected on surveys used to satisfy QI 04A do not meet this requirement.	• **Report**

QI 05 (1 Credit) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A. Clinical quality. B. Patient experience.	
GUIDANCE	**EVIDENCE**
The practice stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics (e.g., age, gender, language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability, health status). The intent of this criterion is for the practice to work toward eliminating disparities in health and delivery of health care for its vulnerable patient populations. **Vulnerable populations** are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability" (AHRQ).	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI Competency A: Measuring Performance.

QI 06 (1 Credit) Validated Patient Experience Survey Use: The practice uses a standardized, validated patient experience survey tool with benchmarking data available.	
GUIDANCE	**EVIDENCE**
The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) PCMH survey, CAHPS-CG or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. It may not be a proprietary instrument. The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.	• **Report**
QI 07 (2 Credits) Vulnerable Patient Feedback: Obtains feedback from vulnerable patient groups on the experiences of disparities in care or services.	
GUIDANCE	**EVIDENCE**
The practice identifies a vulnerable population where data (clinical, resource stewardship, quantitative patience experience, access) show evidence of disparities of care or services. The practice obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.	• **Report**

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QI Competency B: Setting Goals and Acting to Improve.

Competency B: Setting Goals and Acting to Improve. The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.

QI 08 (Core) Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories: A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures.	
GUIDANCE	**EVIDENCE**
Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Measures selected for improvement are chosen from the set of measures identified in QI 01. The goal is for the practice to reach a desired level of achievement based on a self-identified standard of care. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/).	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI Competency B: Setting Goals and Acting to Improve.

QI 09 (Core) Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship:

A. Measures related to care coordination.

B. Measures affecting health care costs.

GUIDANCE	EVIDENCE
The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. Measures selected for improvement may be chosen from the same set of measures identified in QI 02. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement. The Institute for Healthcare Improvement is a resource for the PDSA cycle (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/).	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 10 (Core) Goals and Actions to Improve Appointment Availability: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.

GUIDANCE	EVIDENCE
Knowing that a variety of factors (e.g., season, patient need, practice resource) can affect appointment availability, the practice can adjust to meet patient preferences and needs. After assessing performance on the availability of common appointment types in QI 03, the practice sets goals and acts to improve on availability. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. Practices that have met their appointment-availability access goals in QI 03 and cannot reasonably adjust their goals or identify room for improvement (practices with open-access scheduling) may select another patient-access area (e.g., time spent in the waiting room, no show rates, extended hours, alternative visit types) as their focus.	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI Competency B: Setting Goals and Acting to Improve.

QI 11 (Core) Goals and Actions to Improve Patient Experience: Sets goals and acts to improve performance on at least one patient experience measure.

GUIDANCE	EVIDENCE
After assessing performance on at least one patient experience measure (QI 04), the practice demonstrates that it set a goal for improving patients' experience of care and is working to meet the stated goal. The practice acts to reach a desired level of achievement based on its self-identified standard of care.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 12 (2 Credits) Improved Performance: Achieves improved performance on at least two performance measures.

GUIDANCE	EVIDENCE
The practice demonstrates that it has improved performance on at least two measures. Demonstration of improvement is determined by the goals set in QI 08, QI 09 or QI 11.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 13 (1 Credit) Goals and Actions to Improve Disparities in Care/Service: Sets goals and acts to improve performance on at least one measure of disparities in care or services.

GUIDANCE	EVIDENCE
After assessing performance in care or services among vulnerable populations (QI 05), the practice identifies disparities, sets goals and acts to improve performance.	• **Report** ***OR*** • **Quality Improvement Worksheet**

QI 14 (2 Credits) Improved Performance for Disparities in Care/Service: Achieves improved performance on at least one measure of disparities in care or service.

GUIDANCE	EVIDENCE
The practice demonstrates that it has improved performance on at least one measure related to disparities in care or service. Demonstration of improvement is determined by the goals set in QI 13.	• **Report** ***OR*** • **Quality Improvement Worksheet**

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QI Competency C: Reporting Performance.

Competency C: Reporting Performance. The practice is accountable for performance and shares data within the practice, with patients and/or publicly for the measures and patient populations identified in the previous section.

QI 15 (Core) Reporting Performance within the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice provides individual clinician or practice-level reports to clinicians and practice staff. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations (e.g., a larger medical group, individual practice association or health plan).	• **Documented process** ***AND*** • **Evidence of implementation**

QI 16 (1 Credit) Reporting Performance Publicly or with Patients: Shares clinician-level or practice-level performance results publicly or with patients for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice shares individual clinician or practice-level reports with patients and the public. Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan.	• **Documented process** ***AND*** • **Evidence of implementation**

QI 17 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	• **Documented process** ***AND*** • **Evidence of implementation**

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QI Competency C: Reporting Performance.

QI 18 (2 Credits) Reporting Performance Measures to Medicare/Medicaid: Reports clinical quality measures to Medicare or to a Medicaid agency.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it reports a minimum number of clinical quality measures to Medicare or to a state Medicaid agency: • At least one immunization measure. • One preventive care measure (not including immunizations). • One chronic or acute care clinical measure. • One behavioral health measure.	• **Evidence of submission** 
QI 19 (*Maximum* 2 Credits) Value-Based Contract Agreements: Is engaged in a value-based agreement. A. Practice engages in upside risk contract (1 Credit). B. Practice engages in two-sided risk contract (2 Credits).	
GUIDANCE	**EVIDENCE**
The practice demonstrates it participates in a value-based program by providing information about its participation or a copy of agreement. Involvement in value-based contracts represents a shift from fee-for-service billing to compensating practices and providers for administering quality care for patients. Participation in these programs signals that a practice is willing to be accountable for the value of care provided, rather than emphasizing the volume of services provided. **Upside Risk Contract:** A value-based program where the clinician/practice receives an incentive for meeting performance expectations but does not share losses if costs exceed targets. **Two-Sided Risk Contract:** A value-based program where the clinician/practice incurs penalties for not meeting performance expectations, but receives incentives when care requirements of the agreement are met. Expectations relate to quality and cost.	• **Agreement** ***OR*** • **Evidence of implementation** 

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