NCQA's PCMH 2014 Standards
MPM Functionality Guide

Std	Ele	Fac	Description	Summary	Documentation	Current product feature supporting this element	Current product reporting options	Notes on clinic processes	Prioritization
1			**Patient-Centered Access**	**The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.**					
1	**A**		**Patient-Centered Appointment Access (MUST-PASS)**	**The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:**					**Must-Pass element**
1	A	1	Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)	The practice reserves time for same-day appointments for routine and urgent care based on patient preference and need. Adding ad hoc or unscheduled appointments to a full day of scheduled appointments does not meet the requirement.	Documented process for scheduling same-day appointments that includes defining appointment types and a report with at least five days of data, showing the availability and use of same-day appointments for both urgent and routine care.	Use specific SCH appointment types (ex. Walk-ins) and appointment groups defined for tracking the availability and use of same-day appointments.			Critical factor
1	A	2	Providing routine and urgent-care appointments outside regular business hours.	The practice offers access to care beyond regular business hours. Practices should first assess needs of patients and then evaluate if appointment times meet their needs. If the practice does not provide care beyond regular office hours (e.g., a small practice with limited staffing), it may arrange for patients to receive care from other (non-ER, non-urgent care) facilities or clinicians.	Documented process and a report showing after hours availability for at least five days, or materials provided to patients demonstrating that the practice provides regular extended hours.	Use SCH resource schedules to allow providers to be booked outside of the provider's available profile, or create a new appointment type for after-hour appointments.			
1	A	3	Providing alternative types of clinical encounters.	The practice schedules meetings between patient and clinician using a mode of real time communication instead of an in-person office visit, such as telephone, video chat, or secure instant messaging.	Documented process for arranging appointments for alternative types of encounters and report of encounter types and dates that includes frequency of scheduled alternative encounter types over 30 days.	Use appointment types to distinguish between in-person visits and alternative visits.	SCH Statistical Reports		
1	A	4	Availability of appointments.	The practice has standards for appointment availability for a variety of appointment types.	Documented process defining practice's standards for timely appointment availability and for monitoring against standards and a report of at least five days data showing appointment wait times compared with defined standards.	Use Appointment Types and the MPM Scheduling Desktop.			
1	A	5	Monitoring no-show rates.	The practice monitors no-show rates to provide consistent access and help understand true demand.	Documented process for monitoring scheduled visits and a report from recent 30 days showing number of scheduled visits, number of patients actually seen, number of no-shows, and a calculated rate of patients seen/scheduled visits OR the number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e. a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during that time.	Run Appointment Status Report in SCH or use Practice Mode to sort by "No Show" appointments.	SCH Appointment Status Report		
1	A	6	Acting on identified opportunities to improve access.	The practice uses information gathered from reports in factors 1-5 to identify opportunities to improve access. May implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA).	Documented process for selecting, analyzing and updating approach to creating access to appointments considering supply and patient demand; also a report showing practice has evaluated data on access, selected at least one opportunity to improve access and took at least one action to create greater access.	Use the SCH routines and reports above to analyze/improve processes.	SCH Reports		
1	**B**		**24/7 Access to Clinical Advice**	**The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:**					
1	B	1	Providing continuity of medical record information for care and advice when office is closed.	Patient clinical info is available to on-call staff and external facilities for after-hours care; can be via EHR, PHR, or CCD.	Documented process for giving staff and patients access to medical record information for care and advice when the office is closed.	Use remote access capabilities to access patient records after hours; allow access to patient's CCD via Print or Transmit CCD routines.	N/A		
1	B	2	Providing timely clinical advice by telephone. (CRITICAL FACTOR)	Patients can seek and receive interactive advice by phone when office is open or closed.	Documented process and report measuring response times for at least seven days (may be system generated).	Use PWM Messaging tasks/EAR Chart notes for documenting patient phone calls; use remote acccess capabilities to access patient record/desktop after hours.			Critical factor

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1	B	3	Providing timely clinical advice using a secure, interactive electronic system.	Patients can seek and receive interactive advice by secure electronic communication when office is open or closed.	Documented process and report measuring response times for at least seven days (may be system generated).	Use Portal functionality and PWM Desktop tasks for electronic messaging between provider and patient; use remote acccess capabilities to access patient record/desktop after hours.			
1	B	4	Documenting clinical advice in patient records.	Clinical advice must be documented in the record, whether provided by telephone or electronic message when the office is open or closed.	Documented process and at least three examples of clinical advice documented in the patient record, where at least one example must be from when the office was open and at least one example must be from when the office was closed.	Use remote access capabilities to document advice given to patients after hours; Use chart notes for documenting phone conversations, and use PWM tasks and Portal functionality for electronic messaging between provider and patient.	N/A		
1	**C**		**Electronic Access**	**The following information and services are provided to patients/families/ caregivers, as specified, through a secure electronic system.**	**Practices with a web site or portal should provide the url.**				
1	C	1	More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice.	Patients (and others with legal authorization to the information) have timely online access to their health information after the information is available to the practice.	Report covering at least three months showing the percentage of patients who have timely online access to their health information.	Use Letters/Check Out routine to provide Portal setup instructions, which allows patient to access health information via Portal.	*View, Download, and Transmit First Measure SQL Report		Meaningful Use
1	C	2	More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party.	Patients can view their health information electronically, download or transmit it to a third party.	Report covering at least three months showing the percentage of patients who view their health information, download it or transmit it to a third party.	Use Portal to allow patient to view/download/transmit their health information.	*View, Download, and Transmit Second Measure SQL Report		Meaningful Use
1	C	3	Clinical summaries are provided within 1 business day for more than 50 percent of office visits.	A clinical summary is provided to patients/families/caregivers. Electronic or paper copies are acceptable.	Report covering at least three months showing the percentage of office visits for which clinical summaries were provided to patients.	Provide patients with a printed Visit Summary through the Check Out routine and/or send an electronic copy to their Portal.	*SQL Visit Summary Report		Meaningful Use
1	C	4	A secure message was sent by more than 5 percent of patients.	The practice demonstrates the capability for patients to send a secure message.	Screenshot or report covering at least three months showing the percentage of patients who sent a secure message.	Use Portal and PWM desktop tasks to communicate electronically with the patient.	*SQL Secure Messaging Report		Meaningful Use
1	C	5	Patients have two-way communication with the practice.	The practice utilizes an interactive electronic system, such as a website or patient portal.	Screenshot of portal demonstrating two-way communication capability	Use Portal and PWM desktop tasks to communicate electronically with the patient.	N/A		
1	C	6	Patients can request appointments, prescription refills, referrals and test results.	Patients can use the electronic system to request items, such as appointments, medication refills, referrals to other providers and test results.	Screenshot of portal showing where patients request appointments, refills, referrals to other providers, and test results.	Use Portal and PWM desktop tasks to communicate electronically with the patient.	N/A		
2			**Team-Based Care**	**The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.**					
2	**A**		**Continuity**	**The practice provides continuity of care for patients/families by:**	**A team is a primary clinician and associated staff who work with the clinician. A team may also represent a medical residency group assigned under a supervising physician.**				
2	A	1	Assisting patients/families to select a personal clinician and documenting the selection in practice records.	The practice provides patients/families/caregivers with information about the importance of having a personal clinician and care team, and assists in the selection process.	Documented process for patient and family selection of a personal clinician and an example of a patient record that documents patient/family choice of personal clinician.	Use the Care Team functionality in Registration Questionnaire.	N/A		
2	A	2	Monitoring the percentage of patient visits with selected clinician or team.	The practice monitors the percentage of patient visits that occur with a personal clinician, including structured electronic visits and phone visits.	Report with at least five days of data showing the total percentage of patient encounters that occurred with personal clinicians.	Use the Resource Schedule or Appointment Book mode of the SCH Desktop to see visits by provider.			
2	A	3	Having a process to orient new patients to the practice.	The practice has an orientation process for patients new to the practice.	Documented process for orienting patients to the practice.	N/A	N/A		

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2	A	4	Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.	A written care plan focuses on obtaining adult primary, emergency and specialty care and can include: a summary of medical information; list of providers, medical equipment and medications; obstacles to transitioning to an adult care clinician; special care needs; information provided to patient about the transition of care; arrangement for release and transfer of medical records to the adult care clinician, and patient response to the transition. For family medicine practices that do not transition patients from pediatric to adult care, the practice should instead inform patients and families about the concept of the medical home, and the importance of having a primary care clinician to provide regular, evidence-based preventive care and acute adolescent care management.	Pediatric Practices: An example of a written transition plan from pediatric to adult care. Family Medicine Practices: Documented process and materials for outreach to adolescent and young adult patients to ensure continued preventiative, acute, and chronic care management. Internal Medicine Practices: Documented process and materials for receiving adolescent and young adult patients that ensures continued preventative, acute and chronic care management.	Use a specific Doc Tool template to track the transition phase from adolescence to adult care in the patient record.	N/A		
2	**B**		**Medical Home Responsibilities**	**The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:**					
2	B	1	The practice is responsible for coordinating patient care across multiple settings.	The practice coordinates care across settings including behavioral health.	Documented process and materials provided to patients.	Use the Care Team functionality to indicate the different clinicians associated with the patient's care, the CCD to transfer patient information between providers, and the APR Referral Follow-up Worklist to facilitate transitions of care.	N/A		
2	B	2	Instructions for obtaining care and clinical advice during office hours and when the office is closed.	The practice provides information about its office hours, where to seek after-hours care, and how to communicate with the personal clinician and team and instructs patients to give their other providers the personal clinician's information.	See factor 1.	Use Letters/Check Out Routine to provide information to patients.	N/A		
2	B	3	The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.	The practice has comprehensive patient information about: medications; visits to specialists; medical history; health status; recent test results; self-care information; and data from recent hospitalizations, specialty care or ER visits.	See factor 1.	Use the Consume CCD functionality to import patient health information into the EHR, including medications, allergies, and medical prolems as discrete data. Collect patient reported data in Past, Family, Social, and Surgical History components.	N/A		
2	B	4	The care team provides access to evidence-based care, patient/family education and self-management support.	Patients/families/caregivers can expect evidence-based care from their clinician and team, as well as support for self-management of their health and health care.	See factor 1.	Use the Patient Education component to provide patients with materials pertaining to their conditions. This material can be suggested by medical problem, age, sex, and lab results.	N/A		
2	B	5	The scope of services available within the practice including how behavioral health needs are addressed.	The practice is concerned with the whole person care, which includes behavioral healthcare and informs patients/families/caregivers how behavioral healthcare needs are met.	See factor 1.	N/A	N/A		
2	B	6	The practice provides equal access to all of their patients regardless of source of payment.	The practice evaluates and meets the needs of patients, considers accepting Medicare/Medicaid/uninsured patients, and provides equal access to all patients accepted into the practice, regardless of insurance status.	See factor 1.	N/A	N/A		
2	B	7	The practice gives uninsured patients information about obtaining coverage.	The practice provides information to patients/families/caregivers about potential sources of insurance coverage to raise patient awareness of the availability of public health insurance and financial support for care needs.	See factor 1.	N/A	N/A		
2	B	8	Instructions on transferring records to the practice, including a point of contact at the practice.	The practice guides and helps new patients migrate their personal health record from their former provider, including capturing a point of contact at the patient's new or current practice to help coordinate the transition.	See factor 1.	N/A	N/A		
2	**C**		**Culturally and Linguistically Appropriate Services**	**The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:**					

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2	C	1	Assessing the diversity of its population.	The practice uses data to assess the diversity and needs of its population. Data may be collected from all patients directly or may be data about the community served by the practice. Characteristics of diversity may include race, ethnicity, gender identify, sexual orientation and disability.	Report showing assessment of the diversity (race, ethnicity, and at least one other meaningful characteristic of diversity) and language compostion of patient population.	Use ADM standard and custom queries to capture this information and SQL reports to evaluate the data.	APR Clinical Reporting Tool		
2	C	2	Assessing the language needs of its population.	The practice uses data to assess the linguistic needs of its population. Data may be collected from all patients directly or may be data about the community served by the practice.	Report showing assessment of the diversity (race, ethnicity, and at least one other meaningful characteristic of diversity) and language compostion of patient population.	Use ADM standard and custom queries to capture this information and SQL reports to evaluate the data.	APR Clinical Reporting Tool		
2	C	3	Providing interpretation or bilingual services to meet the language needs of its population.	The practice provides interpretation services or multilingual staff. A patient family member or friend fulfilling this role does not meet this standard.	Documentation of the availability of interpretive services, or a policy or statement that the practice uses bilingual staff.	N/A	N/A		
2	C	4	Providing printed materials in the languages of its population.	The practice identifies languages spoken by at least 5 percent of its patient population and makes materials available in those languages, with regard to patient need (e.g., reading level).	Example materials in languages other than English, a screenshot of a link to online materials, or website in languages other than English.	Use the APR Clinical Reporting Tool to identify languages spoken by population, and use the Patient Education component to provide education to patients in their preferred language.	N/A		
2	**D**		**The Practice Team (MUST-PASS)**	**The practice uses a team to provide a range of patient care services by:**	**Managing patient care is a team effort that involves clinical and non clinical staff interacting with patients and working to achieve stated objectives**				**Must-Pass element**
2	D	1	Defining roles for clinical and nonclinical team members.	Job roles and responsibilities emphasize a team-based approach to care.	Descriptions of staff positions or policies and procedures describing staff roles and functions.	N/A	N/A		
2	D	2	Identifying the team structure and the staff who lead and sustain team based care.	The practice delineates responsibilities for sustaining team-based care, and specifies how care teams align to provide patient-centered care. An organizational chart may be used to illustrate how a care team fits in the practice.	Overview of the staffing structure for team-based care.	N/A	N/A		
2	D	3	Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR)	Team meetings may be informal daily meetings or review daily schedules, with follow-up tasks. Communication may include e-mail, tasks, or messages about a patient in the medical record.	Documented process for structured communication between the clinician and other care team members and at least three samples of meeting summaries, checklists, appointment notes or chart notes.	Use PWM task messaging to communicate about a patient.	N/A		Critical factor
2	D	4	Using standing orders for services.	Standing orders (e.g. testing protocols, triggers for prescription orders, medication refills, vaccinations, routine preventative services) may be executed without approval of the clinician (as permitted by law).	At least one example of written standing orders.	Use AOM Order Rules and "Verbal" order source to execute standing orders.	N/A		
2	D	5	Training and assigning members of the care team to coordinate care for individual patients.	Care coordination may include obtaining test and referral results and communicating with community organizations, health plans, facilities and specialists.	Descriptions of staff positions or policies and procedures describing staff roles and functions. A description of training and training schedule or materials showing how staff has been trained in each area.	N/A	N/A		
2	D	6	Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.	Care team members are trained in evidence-based approaches to self management support, such as patient coaching and motivational interviewing.	Descriptions of staff positions or policies and procedures describing staff roles and functions. A description of training and training schedule or materials showing how staff has been trained in each area.	N/A	N/A		
2	D	7	Training and assigning members of the care team to manage the patient population.	Care team members are trained in managing the patient population and addressing needs of patients and families proactively.	Descriptions of staff positions or policies and procedures describing staff roles and functions. A description of training and training schedule or materials showing how staff has been trained in each area.	N/A	N/A		
2	D	8	Holding scheduled team meetings to address practice functioning.	The practice holds scheduled team meetings routinely to improve care for all patients including clinical and nonclinical staff.	Description of team meetings, including the frequency of these meetings, and at least one example of meeting minutes, agendas or staff memos.	N/A	N/A		
2	D	9	Involving care team staff in the practice's performance evaluation and quality improvement activities.	The practice has a documented process for quality improvement activities that includes a description of staff roles and involvement in the performance evaluation and improvement process.	Documented process for quality improvement.	Use the SQL Clinical Quality Measure Reports to evaluate patient data.	N/A		
2	D	10	Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.	The practice has a process for involving patients and their families in its quality improvement efforts.	Documented process for involving patients/families/caregivers in QI teams or on an advisory council.	N/A	N/A		

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3			**Population Health Management**	**The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.**					
3	**A**		**Patient Information**	**The practice uses an electronic system to record patient information, including capturing information for factors 1-13 as structured (searchable) data for more than 80 percent of its patients:**					
3	A	1	Date of birth.	The practice records date of birth in MM/DD/YYYY format.	Report from the electronic system showing the percentage of all patients for each populated data field, where Denominator = number of patients seen by the practice at least once during the reporting period, and Numerator = number of patients in the denominator for whom the specified data are entered.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.	*SQL Demographics Report		Meaningful Use
3	A	2	Sex.	The practice records sex as M/F or Male/Female.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.	*SQL Demographics Report		Meaningful Use
3	A	3	Race.	The practice records patient race. A patient declining to provide the information will qualify for the numerator.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.	*SQL Demographics Report		Meaningful Use
3	A	4	Ethnicity.	The practice records patient ethnicity. A patient declining to provide the information will qualify for the numerator.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.	*SQL Demographics Report		Meaningful Use
3	A	5	Preferred language.	The practice documents the patient's preferred spoken/written language. A patient declining to provide the information will qualify for the numerator.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.	*SQL Demographics Report		Meaningful Use
3	A	6	Telephone numbers.	The practice records the patient's primary telephone number.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.			
3	A	7	E-mail address.	The practice records the patient's e-mail address. The practice enters "none" if a patient does not have an e-mail address or declines to provide one. This counts towards the numerator.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.			
3	A	8	Occupation (NA for pediatric practices).	The practice records the patient's field of employment and instances where a patient is not currently employed. A specific status (retired, disabled, unemployed, student) is used for a patient who is unemployed.	See factor 1, exclude patients by age from the denominator.	Enter this information into the patient record during the registration/check-in process in ADM or SCH.			
3	A	9	Dates of previous clinical visits.	The practice enters all office, electronic and telephone visits into the system. Visits (i.e. structured, scheduled encounters) are distinguished from medical advice given electronically or by telephone.	See factor 1.	Use Portal functionality and PWM task functionality to document electronic advice. Set up separate appointment types to distinguish scheduled telemedicine/e-medicine visits, and EAR chart notes to document online or telephone advice.			
3	A	10	Legal guardian/health care proxy.	The pratice enters an individual designated by the patient, family or court to make health care decisions for a patient, if the patient is unable to do so.	See factor 1.	Designate a proxy through the Care Team functionality during the registration/check-in process in SCH or through Proxy Access in the user setup in the PHM Parameters.			
3	A	11	Primary caregiver.	The practice enters an individual who provides day-to-day care for a patient and receives instructions about care. The practice enters "none" if there is no caregiver. This counts toward the numerator.	See factor 1.	Enter this information into the patient record in the Care Team during the registration/check-in process in ADM or SCH module.			

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3	A	12	Presence of advance directives (NA for pediatric practices).	The practice documents that the patient/family provided an advance directive. The advance directive must be on file at the practice to meet the factor. Practices with adult and pediatric patients may exclude pediatric patients from the denominator for this factor. Documentation in the field that the patient declined to provide the information counts toward the numerator.	See factor 1, exclude patients by age from the denominator.	Scan an advance directive into the patient's record through APR External Documents, and assign the corresponding EMR ID to have it appear correctly in the chart.			
3	A	13	Health insurance information.	The practice documents the patient/family health insurance coverage.	See factor 1.	Enter this information into the patient record during the registration/check-in process in ADM or SCH module.			
3	A	14	Name and contact information of other health care professionals involved in patient's care.	The practice records the name and contact information for the patient's other health care clinicians providing care. Collecting the information in the electronic patient chart or electronic care plans is acceptable. Note: This factor does not require the field to be searchable or structured data.	Documented process for capturing the data and three examples demonstrating implementation of the process.	Enter this information into the patient record through the Care Team functionality during the registration/check-in process in ADM or SCH module.	N/A		
3	**B**		**Clinical Data**	**The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1-5 and 8-11 as structured (searchable) data.**					
3	B	1	An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.	The practice documents the patient's current and active problem list or diagnoses including acute and chronic conditions, behavioral health diagnoses and oral health issues.	Report from the electronic system showing the percentage of all unique patients for each populated data field, where Denominator = Number of patients seen by the practice at least once during the reporting period, and Numerator = Number of patients in the denominator for whom the specified data are entered.	Use the Problem List (through Doc Tool or the patient's chart) to note visit-specific, acute, and chronic diagnoses.	*SQL Medical Problems Report		Meaningful Use
3	B	2	Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.	The practice records allergies (i.e. medication, food, environmental) and associated reations as searchable data.	See factor 1.	Use the Allergies component, accessible enterprise-wide, to track patient allergies and adverse reactions.	*SQL Med Allergies Report		Meaningful Use
3	B	3	Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.	The practice records dated blood pressure readings for patients 3 years and older; NA for practices with no patients 3 years and older.	See factor 1, exclude patients by age from the denominator.	Use the Vitals component in Doc Tool to record blood pressure for patients.	*SQL Vital Signs Report		Meaningful Use
3	B	4	Height/length for more than 80 percent of patients	The practice records and dates height/length for more than 80 percent of patients.	See factor 1.	Use the Vitals component in Doc Tool to record height for patients.	*SQL Vital Signs Report		Meaningful Use
3	B	5	Weight for more than 80 percent of patients	The practice records and dates weight for more than 80 percent of patients.	See factor 1.	Use the Vitals component in Doc Tool to record weight for patients.	*SQL Vital Signs Report		Meaningful Use
3	B	6	System calculates and displays BMI.	The practice's electronic system calculates and displays BMI in the medical record. Note: This factor does not require the field to be searchable or structured.	Screenshots demonstrating that the electronic system can calculate and display BMI.	Enter a patient's height and weight to display a calculated BMI in the Vitals component.	N/A		
3	B	7	System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).	The practice's electronic system plots and displays length, weight, and head circumference on a growth chart for patients 0-2 years of cage, and BMI percentile for patients 2-20 years of age. Note: This factor does not require the field to be searchable or structured.	Screenshot demonstrating that the electronic system can plot and display growth charts and BMI percentile. Include only patients who meeting the age parameter.	Use the Vitals component and EAR Growth Chart to display relevant vitals for patients who meet certain age parameters.	N/A		
3	B	8	Status of tobacco use for patients 13 years and older for more than 80 percent of patients.	The practice records status of tobacco use.	See factor 1, exclude patients by age from the denominator.	Use Doc Tool queries to capture this information.	*SQL Smoking Status Report		Meaningful Use
3	B	9	List of prescription medications with date of updates for more than 80 percent of patients.	The practice maintains a list of current prescription medications prescribed by the patient's clinicians, including clinicians outside the practice and records dates of updates. Record NA in the field if the patient does not take prescribed medications.	See factor 1.	Use the patient's AOM Profile to input and reconcile medications.	*SQL Medication Reconciliation Report		Meaningful Use
3	B	10	More than 20 percent of patients have family history recorded as structured data.	The practice documents family health history for "first-degree" relatives. Record "unknown" for patients who do not know their family health history.	See factor 1.	Use the PFSH Doc Tool queries or the PFSH component to capture this information. Mark "No Known History" for patients who do not know of any relevant family history.	*SQL Family History Report		Meaningful Use

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3	B	11	At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.	Progress notes are text-searchable. The practice coordinates new progress notes with previous documentation of patient observations, treatments and results.	See factor 1. Note: In response to the Meaningful Use Modified Stage 2 Final Rule, NCQA will accept an example of capability in lieu of a report for factor 11.	Press Ctl+F to search for any relevant text when viewing a progress note from Doc Tool.	*SQL Electronic Notes Report		Meaningful Use
3	**C**		**Comprehensive Health Assessment**	**To understand health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:**					
3	C	1	Age and gender appropriate immunizations and screenings.	The practice implements age/gender-appropriate screenings and immunizations.	The practice chooses one of these two methods of documentation: 1. Practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor. The report must indicate that data was entered in the medical record for more than 50 percent in order for the practice to respond "yes" to each factor in the survey tool. OR 2. Review the patient records selected for the medical record review as required in elements 4B and 4C and document presence or absence of the information in the Record Review Workbook. For each factor to which the practice responds "yes", it provides one example of how it meets the factor.	Set up age/gender specific screenings through Health Maintenance Items, and order them through AOM, or set up screenings through specific templates within the Doc Tool.		
3	C	2	Family/social/cultural characteristics.	The practice evaluates social and cultural needs, preferences, strengths and limitations. Examples of these characteristics can include family/household structure, support systems, household/environmental risk factors and patient/family concerns.	See factor 1.	Capture this information via query in the PFSH (recommended) or Doc Tool components.	APR Clinical Reporting Tool		
3	C	3	Communication needs.	The practice identifies whether the patient has specific communication requirements due to hearing, vision or cognition issues.	See factor 1.	Capture this information via query in the PFSH (recommended) or Doc Tool components or in the Problem List.	APR Clinical Reporting Tool		
3	C	4	Medical history of patient and family.	The practice documents family medical history for "first-degree" relatives. Record "unknown" for patients who do not know their family health history.	See factor 1.	Capture medical history for patient and relatives through the use of the PFSH component (recommended) or Doc Tool queries.	*SQL Family History Report		
3	C	5	Advance care planning (NA for pediatric practices).	The practice documents patient/family preference for advance care planning. This may include discussing and documenting a plan of care, with treatment options and preferences. Documentation that the patient declined to provide information counts toward the numerator.	See factor 1.	Import documents detailing end of life care plans into the patient's chart via APR External Documents.			
3	C	6	Behaviors affecting health.	The practice assesses risky and unhealthy behaviors. This may include nutrition, oral health, dental care, familial behaviors, risky sexual behavior and secondhand smoke exposure.	See factor 1.	Capture this information via query in the PFSH (recommended) or Doc Tool components.	APR Clinical Reporting Tool		
3	C	7	Mental health/substance use history of patient and family.	The practice assesses whether the patient and the patient's family has any mental health/behavioral conditions or substance abuse issues (i.e., stress, alcohol or drug abuse, illegal drug use, maternal depression).	See factor 1.	Capture this information via query in the PFSH (recommended) or Doc Tool components.	APR Clinical Reporting Tool		
3	C	8	Developmental screening using a standardized tool (NA for practices with no pediatric patients).	For newborns through 3 years, periodic developmental screening is conducted using a standardized test. If there are no established risk factors or parental concerns, screens are done by 24 months.	See factor 1. Additionally, the practice must provide a completed form (de-identified) to receive credit.	Capture this information via query in the PFSH (recommended) or Doc Tool components, or set up through Health Maintenance.	APR Clinical Reporting Tool		
3	C	9	Depression screening for adults and adolescents using a standardized tool.	Screening adults for depression when staff-assisted depression care support systems are in place and screening adolescents (12-18) for MDD when systems are in place.	See factor 1. Additionally, the practice must provide a completed form (de-identified) to receive credit.	Capture this information via query in the PFSH (recommended) or Doc Tool components, or set up through Health Maintenance.	APR Clinical Reporting Tool		

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3	C	10	Assessment of health literacy.	The practice assesses the patient/family/caregiver's ability to understand the concepts and care requirements associated with managing their health.	See factor 1. For practices that do not assess health literacy at the patient level, submit materials or prcessess demonstrating that health literacy is addressed at the practice level.	Capture this information via query in the Doc Tool component.	APR Clinical Reporting Tool		
3	**D**		**Use Data for Population Management (MUST-PASS)**	**At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines, including:**					**Must-Pass element**
3	D	1	At least two different preventative care services.	The practice generates lists of patients and uses the lists to remind identified patients about at least two preventive care services, appropriate to the patients' age or gender, beyond immunizations.	Identified services, reports or lists of patients needing services generated within the past 12 months and materials showing how patients were notified for each service.	Use Health Maintenance and Disease Management reports/letters to remind patients of services upcoming or overdue.	APR Health Maintenance Reports		Meaningful Use
3	D	2	At least two different immunizations.	The practice generates lists of patients and uses the lists to remind identified patients about at least two different immunizations appropriate to the patients' age or gender.	See factor 1.	Use Health Maintenance and Disease Management reports/letters to remind patients of immunizations upcoming or overdue.	APR Health Maintenance Reports		
3	D	3	At least three different chronic or acute care services.	The practice generates lists of patients who need chronic care or acute management services and use the lists to remind identified patients of at least three chronic or acute care services.	See factor 1.	Use Disease Management to track chronic illnesses, run Disease Management reports/letters to remind patients of care services needed.	APR Health Maintenance Reports		
3	D	4	Patients not recently seen by the practice.	The practice generates lists of patients who are overdue for an office visit or service and acts to remind them.	See factor 1.				
3	D	5	Medication monitoring or alert.	The practice generates a list of patients on specific medications. List may be used to: manage patients prescribed medications with potentially harmful side effects; identify patients prescribed a brand-name drug instead of a generic drug; notify patients about a medication recall or warning; remind patients about necessary monitoring because of specific medications; inform patients about drug-drug or dosage concerns.	See factor 1.	Use the APR Compile Clinical Report routine to generate list of patients on a specific medication.	APR Clinical Reporting Tool, RXM Reports		
3	**E**		**Implement Evidence-Based Decision Support**	**The practice implements clinical decision support (e.g., point-of-care reminders) following evidence-based guidelines for:**	**When selecting conditions, the practice considers diagnoses and risk factors prevalent in patients seen by the practice and the availability to evidence-based clinical guidelines.**				
3	E	1	A mental health or substance use disorder. (CRITICAL FACTOR)	The practice has evidence-based guidelines it uses for clinical decision support related to at least one mental health issue or substance abuse issue.	Conditions identified for each factor; source of evidence-based guidelines used by the practice, for each condition; examples of guideline implementation such as tools to manage patient care, organizers, flow sheets or electronic system organizer templates based on condition-specific guidelines.	Use Health Maintenance and Disease Management and Doc Tool templates to track various risk factors/mental health issues/substance abuses issues for the patient. Use AOM Order Rules to suggest diagnostic, referral, or medication orders.	N/A		Critical factor and Meaningful Use
3	E	2	A chronic medical condition.	The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic medical condition. Well-child care is not an acceptable chronic condition for this factor.	See factor 1.	Use Disease Manangement to track assessments and tests associated with a chronic medical condition. Use AOM Order Rules to suggest diagnostic, referral, or medication orders.	N/A		Meaningful Use
3	E	3	An acute condition.	The practice has evidence-based guidelines it uses for clinical decision support related to at least one acute medical condition.	See factor 1.	Use Health Maintenance related to an acute medical condition. Use AOM Order Rules to suggest diagnostic, referral, or medication orders.	N/A		Meaningful Use
3	E	4	A condition related to unhealthy behaviors.	The practice has evidence-based guidelines it uses for clinical decision support related to at least one unhealthy behavior (e.g., obesity, smoking).	See factor 1.	Use Disease Management/Health Maintenance Items to track assessments/tests related to at least one of these unhealthy behaviors. Use AOM Order Rules to suggest diagnostic, referral, or medication orders.	N/A		Meaningful Use
3	E	5	Well child or adult care.	The practice has evidence-based guidelines it uses for clinical decision support related to well-child or adult care (e.g. age appropriate screenings, immunizations).	See factor 1.	Use Health Maintenance/Doc Tool to track screenings and immunizations. Use AOM Order Rules to suggest immunizations.	N/A		Meaningful Use

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3	E	6	Overuse/appropriateness issues.	The practice has evidence-based guidelines it uses for clinical decision support related to overuse or appropriateness of care issues (e.g. use of antibiotics, avoiding unnecessary testing and referrals to multiple specialists).	See factor 1.	Use Health Maintenance/Disease Management/Doc Tool to track conditions to ensure appropriate care. Use AOM Order Rules to suggest diagnostic, referral, or medication orders. Use Drug-Drug Interaction Checking to provide alerts.	N/A		Meaningful Use
4			**Care Management and Support**	**The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.**					
4	**A**		**Identify Patients for Care Management**	**The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:**					
4	A	1	Behavioral health conditions.	The practice has specific criteria for identifying patients with behavioral conditions for whole-person care planning and management.	Documented process that describes the criteria for identifying patients for each factor.	Use the Problem List, PFSH component, Doc Tool and APR Clinical Reports to identify patients.	N/A		
4	A	2	High cost/high utilization.	The practice has specific criteria for identifying patients who experience high utilization or high cost.	See factor 1.	Use the shared EMR, APR Referral Follow-up Worklist, RXM Reports, and APR Clinical Reports to identify patients.	N/A		
4	A	3	Poorly controlled or complex conditions.	Patients who consistently fail to meet treatment goals or with multiple comorbid conditions may be included in the criteria for this factor.	See factor 1.	Use the Problem List, APR Clinical Reports, and Doc Tool to identify patients.	N/A		
4	A	4	Social determinants of health.	The practice has a process for identifying patients based on social determinants of health. Social determinants of health are conditions in the environment that affect a wide range of health, functioning and quality-of-life outcomes and risks.	See factor 1.	Use the Doc Tool, PFSH component, and APR Clinical Reports to identify patients.	N/A		
4	A	5	Referrals by outside organizations, practice staff or patient/family/caregiver.	The practice has a process based on these criteria that is intended to allow for referrals by external entities and nominations by those closest to patients/families/caregivers.	See factor 1.	Use the Doc Tool and APR Clinical Reports to identify patients.	N/A		
4	A	6	The practice monitors the percentage of the total patient population identified through its process and criteria. (CRITICAL FACTOR)	The practice completes an assessment of a combination of factors 1–5 results in a subset of the practice's entire panel of patients identified as likely to benefit from care management.	Report showing the number and percentage of patients identified as likely to benefit from care management, where Denominator = Total number of patients in practice, and Numerator = Number of unique patients identified in the denominator as likely to benefit from care management by the criteria in factors 1-5.	Assess results using the product features listed above.	APR Clinical Reporting Tool		Critical factor
4	**B**		**Care Planning and Self-Care Support (MUST-PASS)**	**The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:**					**Must-Pass element**
4	B	1	Incorporates patient preferences and functional/lifestyle goals.	The practice works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan and updates the plan at relevant visits.	Report from electronic system or use Record Review Workbook, where Denominator = Total number of patients identified through the criteria in Element A seen at least once for a relevant visit by the practice in a recent three-month period, and Numerator = Number of patients identified in the denominator for whom each item is entered in the medical record.	Use the Goals/Instructions component of Doc Tool to record patient preferences and goals.			
4	B	2	Identifies treatment goals.	The practice works with patients/families/caregivers and other providers to develop treatment goals using evidence-based guidelines.	See factor 1.	Use the Goals/Instructions component of Doc Tool to record patient preferences and goals.			
4	B	3	Assesses and addresses potential barriers to meeting goals.	The practice works with patients/families/caregivers, other providers and community resources to assess and address potential barriers to achieving treatment and functional/lifestyle goals.	See factor 1.	Use the Goals/Instructions component of Doc Tool to record patient preferences and goals.			

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4	B	4	Includes a self-management plan.	The practice works with patients/families/ caregivers to develop a self-management plan. Patients/family/caregivers that manage complex conditions or may have other significant potential barriers (factor 3) are given instructions and resources, as appropriate. The self-management plan includes goals and a way to monitor self-care. If the patient is meeting treatment goals, documentation could be that the patient is meeting treatment goals with documentation that the patient was instructed to maintain the current self-care plan.	See factor 1.	Use the Goals/Instructions component of Doc Tool to record patient preferences and goals. Use the Patient Education component to provide patient with relevant resources.			
4	B	5	Is provided in writing to the patient/family/caregiver.	The written individualized care plan is given to the patient/family/caregiver. When possible, the plan is tailored to account for health literacy and language considerations.	See factor 1.	Add patient instructions in the Care Plan component within Doc Tool. Print and provide Visit Summary to patients which includes Care Plan details.			
4	**C**		**Medication Management**	**The practice has a process for managing medications, and systematically implements the process in the following ways:**					
4	C	1	Reviews and reconciles medications for more than 50 percent of patients received from care transitions. (CRITICAL FACTOR)	The practice reviews and documents in the medical record all prescribed medications the patient is taking. Medication review and reconciliation occurs, at least annually, at transitions of care and at relevant visits.	Report from electronic system or use Record Review Workbook, where Denominator = Total number of patients identified through the criteria in Element A seen at least once for a relevant visit by the practice in a recent three-month period, and Numerator = Number of patients identified in the denominator for whom each item is entered in the medical record.	Use AOM to reconcile patient medications.	*SQL Medication Reconciliation Report		Critical factor and Meaningful Use
4	C	2	Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	The practice reviews and documents in the medical record all prescribed medications the patient is taking. Medication review and reconciliation occurs, at least annually, at transitions of care and at relevant visits.	See factor 1.	Use AOM to reconcile patient medications.	*SQL Medication Reconciliation Report		Meaningful Use
3	C	3	Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.	The practice provides patients/families with information about a new medication, including potential side effects, drug interactions, instructions for taking the medication and the consequences of not taking it.	See factor 1.	Print prescription monographs directly from AOM or through the Check Out routine.			
4	C	4	Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.	The practice assesses how well patients understand the information about medications they are taking, and considers a patient's health literacy.	See factor 1.	Use Doc Tool queries to document that patient's understanding of medication was assessed.	APR Clinical Reporting Tool		
4	C	5	Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.	The practice asks patients about a problem or difficulty taking a medication; whether they are experiencing side effects; and whether the medication is being taken as prescribed. If a patient is not taking a medication as prescribed, the practice determines why.	See factor 1.	Use Doc Tool queries to document patient's response and adhearence to medications.	APR Clinical Reporting Tool		
4	C	6	Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.	At least annually, the practice reviews and documents in the medical record the nonprescription medications, such as over-the-counter (OTC) medications, herbal therapies and supplements that the patient is taking to prevent interference with prescribed medication and to evaluate potential side effects.	See factor 1.	Use AOM to add reported OTC medications and supplements.	*SQL Medication Reconciliation Report		
4	**D**		**Use Electronic Prescribing**	**The practice uses an electronic prescription system with the following capabilities:**					
4	D	1	More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.	More than 50 percent of eligible prescriptions written by the practice are: compared with drug formularies to identify covered drugs and the copayment tier, if applicable, and sent to pharmacies electronically.	Screenshots and Report from electronic system, where Denominator = Eligible prescriptions written by the practice, and Numerator = Eligible prescriptions generated by the practice that are compared with drug formularies and transmitted to pharmacies from the practice's electronic prescribing system.	Use e-Prescribing functionality within AOM and DrFirst integration to transmit prescriptions.	*SQL ePrescribing Report		Meaningful Use

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4	D	2	Enters electronic medication orders in the medical record for more than 60 percent of medications.	The practice's electronic prescribing system is integrated with patient records, allowing the practice to view patient diagnoses and patient medications; enter new medications or make changes; and identify documented allergies. The practice enters more than 60 percent of prescribed medication orders in the integrated electronic prescribing system.	Report from electronic system, where Denominator = Number of medication orders created by the practice during the EHR reporting period, and Numerator = Number of medication orders in the denominator recorded using the computerized physician order entry (CPOE) system integrated with the electronic medical record	Use the patient's AOM Profile for entering medication orders.	*SQL CPOE Medications Orders Report		Meaningful Use
4	D	3	Performs patient-specific checks for drug-drug and drug-allergy interactions.	When a new prescription request is entered, the practice's electronic prescribing system alerts the clinician to potentially harmful, patient-specific interactions between drugs and to a patient's drug allergy.	Reports from electronic system or screenshots.	Enable interaction checking in AOM.			
4	D	4	Alerts prescribers to generic alternatives.	The system alerts the clinician to cost-effective, generic options to name-brand medications.	Reports from electronic system or screenshots.	Enable Drug Formulary Benefit Status checking in AOM.	*SQL Stage 2 ePrescribing Report		
4	**E**		**Support Self-Care and Shared Decision Making**	**The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:**					
4	E	1	Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.	The practice uses an EHR to identify patient-specific educational resources and provides the resources to more than 10 percent of its patients.	Report from electronic system, where Denominator = Number of unique patients in the practice's system, and Numerator = Number of patients in the denominator with at least one educational resource electronically recorded in the patient record.	Use the Patient Instructions component and Info Button in Doc Tool, and drug monographs in AOM. Print materials through the Check Out routine.	*SQL Patient Education Report		Meaningful Use
4	E	2	Provides educational materials and resources to 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, Web site links and pamphlets, as well as community resources (e.g., programs, support groups).	At least three examples of resources, tools or aids.	N/A	N/A		
4	E	3	Provides self-management tools to record self-care results.	Self-management tools enable patients to collect health information at home that can be discussed with the clinician.	At least three examples of resources, tools or aids.	N/A	N/A		
4	E	4	Adopts shared decision making aids.	When a complex decision involves multiple options with features that people may value differently, a shared decision-making aid provides detailed information without advising the audience to choose one decision over another.	At least three examples of resources, tools or aids.	N/A	N/A		
4	E	5	Offers or refers patients to structured health education programs, such as group classes and peer support.	The practice provides (or makes 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).	At least three examples of resources, tools or aids.	N/A	N/A		
4	E	6	Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.	The resource list is specific to the needs of the practice's population—not necessarily specific to criteria and areas of focus a practice uses to identify patients likely to benefit from care management (identified in Element 4A), and includes programs and services to help patients in self-care or to give the patient population access to care related to at least five topics or key community service areas of importance.	Materials demonstrating that the practice offers at least five resources.	N/A	N/A		
4	E	7	Assesses usefulness of identified community resources.	The practice reviews and requests feedback from patients/families/caregivers about community referrals, to evaluate whether it identified sufficient and appropriate resources for its population over time.	Survey or other materials showing how the practice collects information on the usefulness of referrals to community resources.	N/A	N/A		
5			**Care Coordination and Care Transitions**	**The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.**					
5	**A**		**Test Tracking and Follow-Up**	**The practice has a documented process for and demonstrates that it:**					

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5	A	1	Tracks lab tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)	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.	A documented process and evidence showing how the process is met for each factor such as a report or a log or examples.	Use AOM Orders functionality and PWM Result tasks.	PWM Results Reports, RXM Compile Overdue Orders Report		Critical factor
5	A	2	Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)	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.	See factor 1.	Use AOM Orders functionality and PWM Result tasks.	PWM Results Reports, RXM Compile Overdue Orders Report		Critical factor
5	A	3	Flags abnormal lab results, bringing them to the attention of the clinician.	Abnormal results of lab tests are flagged or highlighted and brought to the attention of the clinician, to ensure timely follow-up with the patient/family.	See factor 1.	Define normal range in LAB and APR results. PWM Result tasks flag abnormal results.			
5	A	4	Flags abnormal imaging results, bringing them to the attention of the clinician.	Abnormal results of imaging tests are flagged or highlighted and brought to the attention of the clinician, to ensure timely follow-up with the patient/family.	See factor 1.				
5	A	5	Notifies patients/families of normal and abnormal lab and imaging test results.	The practice is proactive in notifying patients about test results (normal and abnormal).	See factor 1.	Use Result Letters and Portal to provide timely access to results.			
5	A	6	Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).	The practice follows up with the hospital or state health department if it does not receive screening results.	See factor 1.	Use the CC Provider functionality within tasks and CCDs to receive results from inpatient facilities.			
5	A	7	More than 30 percent of laboratory orders are electronically recorded in the patient record.	Lab test orders are recorded in the patient medical record electronically.	Report from electronic system, where Denominator = Number of lab tests ordered during the reporting period, and Numerator = Number of lab tests ordered that are electronically recorded in the patient record.	Enter laboratory orders in AOM.	*SQL CPOE Lab Report		Meaningful Use
5	A	8	More than 30 percent of radiology orders are electronically recorded in the patient record.	Imaging test orders are recorded in the patient medical record electronically.	Report from electronic system, where Denominator = Number of radiology tests ordered during the reporting period, and Numerator = Number of radiology tests ordered that are electronically recorded in the patient record.	Enter radiology orders in AOM.	*SQL CPOE RAD Report		Meaningful Use
5	A	9	Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.	The practice electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical records.	Screenshot or report from electronic system, where Denominator = Number of lab tests ordered during the reporting period with results expressed in a positive or negative affirmation or as a number, and Numerator = Number of lab tests whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.	Incorporate results through the LAB module, HL7 Lab Interface, and APR Result Entry.	*SQL Incorporate Lab Results Report		Meaningful Use
5	A	10	More than 10 percent of scans and tests that result in an image are accessible electronically.	Imaging results that include a written report and may include images are integrated into the medial record electronically.	Screenshot or report from electronic system, where Denominator = Number of tests whose result is one or more images ordered during the reporting period, and Numerator = Number of imaging results in the denominator that are accessible through the practice's electronic system.	Enter Imaging results through ITS and APR External Results.	*SQL Incorporate Imaging Results Report		Meaningful Use
5	**B**		**Referral Tracking and Follow-Up (MUST-PASS)**	**The practice:**					**Must-Pass element**
5	B	1	Considers available performance information on consultants/specialists when making referral recommendations.	The practice uses available data on the performance of clinicians and practices to which it refers its patients.	Examples.	N/A	N/A		
5	B	2	Maintains formal and informal agreements with a subset of specialists based on established criteria.	Agreements between primary care and the specialist may be formal or informal and may describe the expectations or embed them in a tool such as a referral request form.	At least one example.	N/A	N/A		
5	B	3	Maintains agreements with behavioral healthcare providers.	The practice maintains at least one agreement with a behavioral health specialist.	At least one example.	N/A	N/A		
5	B	4	Integrates behavioral healthcare providers within the practice site.	The practice integrates partially (i.e., co-location with some systems in common) or fully (i.e., co-location with all systems shared) with behavioral health care.	Materials that explain how behavioral health is integrated with physical health.	N/A	N/A		
5	B	5	Gives the consultant or specialist the clinical question, the required timing and the type of referral.	The referring clinician provides a succinct reason for the referral, which may be stated as "the clinical question" (i.e., the general purpose of the referral) to be answered by the specialist. Indicates the urgency of the referral in concrete terms and includes details about the reasons for an urgent visit.	A documented process and a report, log, or other means demonstrating that its process is followed. A paper log or screenshot showing electronic capabilities is acceptable.	Use AOM Referral Orders to enter this information.			

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5	B	6	Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.	Referrals include relevant clinical information, such as: current medications, diagnoses, clinical findings and current treatment, follow-up communication or information, and patient demographic information.	A documented process and a report, log, or other means demonstrating that its process is followed. A paper log or screenshot showing electronic capabilities is acceptable.	Use AOM Referral Orders and CCDs generated from a task or the APR Referral Follow-up Worklist.	*SQL Transitions of Care Report 1st Measure		Meaningful Use
5	B	7	Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.	The practice demonstrates the capability for electronic exchange of key clinical information with other providers or settings of care and provides an electronic summary-of-care record for more than 50 percent of referrals.	A screenshot and a report from electronic system, where Denominator = Number of transitions of care and referrals, and Numerator = Number of transitions of care and referrals in the denominator where a summary care record was provided electronically.	Use AOM Referral Orders and electronically send the patients' CCDs via Direct Messaging.	*SQL Stage 2 Transitions of Care Report 2nd Measure		Meaningful Use
5	B	8	Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL FACTOR)	A tracking report includes the date when a referral was initiated and the timing indicated for receiving the report.	A documented process and a report, log, or other means demonstrating that its process is followed. A paper log or screenshot showing electronic capabilities is acceptable.	Use the APR Referral Follow-up Worklist to track referrals.	APR Referral Worklist, *Clinical Quality Measure CMS 50		Critical factor
5	B	9	Documents co-management arrangements in the patient's medical record.	For patients who are regularly treated by a specific specialist, the primary care clinician and the specialist enter into an agreement that enables co-management of the patient's care.	At least three examples.	N/A	N/A		
5	B	10	Asks patients/families about self-referrals and requesting reports from clinicians.	Clinicians routinely ask patients if they have seen a specialist or are receiving care from a specialist and, if so, request a report from the specialist, to be documented in the medical record.	A documented process and a report, log, or other means demonstrating that its process is followed. A paper log or screenshot showing electronic capabilities is acceptable.	Use Incorporate CCD functionality to add information from the specialist to the patient's chart.			
5	**C**		**Coordinate Care Transitions**	**The practice:**	**For factors requiring a documented process, the documented process includes a date of implementation or revision and has been in place for at least three months prior to submitting the PCMH 2014 Survey Tool.**				
5	C	1	Proactively identifies patients with unplanned hospital admissions and emergency department visits.	The practice works with local hospitals, ERs and health plans to identify patients who were hospitalized and patients who had ER visits.	A documented process and a log of patients receiving care from different types of facilities or a report listing patients seen in the ER or hospital.	Use ADT Desktop Notice tasks to identify patients who recently visited the hospital.	PWM Task Audit Report		
5	C	2	Shares clinical information with admitting hospitals and emergency departments.	The practice provides facilities with appropriate and timely information about patients.	A documented process and at least three de-identified examples of patient information sent to the hospital or ER.	Use the Shared EMR and CCD Direct Messaging to communicate patient information with the acute environment.	N/A		
5	C	3	Consistently obtains patient discharge summaries from the hospital and other facilities.	The practice or external organization has a process for obtaining patient discharge summaries from hospitals, ERs, skilled nursing facilities, surgical centers and other facilities.	A documented process and at least three examples of a discharge summary.	Use the Shared EMR and ADT Discharge Notice tasks to access patients' discharge summaries.	N/A		
5	C	4	Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.	The practice contacts patients to evaluate their status after discharge from an ER or hospital and to make a follow-up appointment, if appropriate.	A documented process for patient follow-up after a hospital admission or ER visit and at least three de-identified examples of documented patient follow-up in the medical record, or a log documenting systematic follow-up.	Use ADT Desktop Notice tasks and Chart Notes to evaluate status after discharge, and use SCH to book a follow-up appointment.	PWM Task Audit Report		
5	C	5	Exchanges patient information with the hospital during a patient's hospitalization.	The practice has a two-way communication plan with hospitals to exchange information about hospitalized patients, enabling well-coordinated care during and after hospitalization.	A documented process and an example of two-way communication.	Use the Shared EMR and CCD Direct Messaging to communicate patient information with the acute environment.	N/A		
5	C	6	Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners.	The practice has a process for working with community partners to obtain appropriate consent for release of information to treat and coordinate care with those partners who have legal responsibility for certain patients.	A documented process for obtaining proper consent for release of information.	Use Confidentiality functionality in various modules to limit access without proper consent.	N/A		
5	C	7	Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.	The practice demonstrates the capability for electronic exchange of key clinical information with other settings of care or providers and provides an electronic summary-of-care record for more than 50 percent of transitions to another setting of care or referrals to another provider.	Screenshot and report from electronic system, where Denominator = Number of transitions of care and referrals, and Numerator = Number of transitions of care and referrals in the denominator where a summary care record was provided electronically.	Use CCD Direct Messaging to send and receive clinical information electronically.	*SQL Stage 2 Transition of Care 2nd Measure Report		Meaningful Use
6			**Performance Measurement and Quality Improvement**	**The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience**					
6	**A**		**Measure Clinical Quality Performance**	**At least annually, the practice measures or receives data on:**					

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6	A	1	At least two immunization measures.	The practice measures rates of immunization appropriate to the populations it manages.	Reports showing performance: period of measurement, number of patients represented by the data, rate (percent) based on numerator and demoniator. For Renewal Surveys, reports much be at least annually for two years.	Use Health Maintenance to track immunizations.	*SQL Reports for CMS 147, CMS 117, CMS 127		Meaningful Use
6	A	2	At least two other preventive care measures.	Preventive measures encompass a practice's entire population and are not limited to specific measures for a patient population with chronic conditions. The intent is that the practice develops activities to improve quality of care for all patients.	See factor 1.	Use Health Maintenance to track preventative care measures.	*SQL Clinical Quality Measure Reports		Meaningful Use
6	A	3	At least three chronic or acute care clinical measures.	Chronic or acute care clinical measures may be associated with the conditions that are tracked by the practice based on evidence-based guidelines.	See factor 1.	Use Disease Management to track chronic or acute conditions.	*SQL Clinical Quality Measure Reports		Meaningful Use
6	A	4	Performance data stratified for vulnerable populations (to assess disparities in care).	Data collected by the practice for one or more measures from factors 1–3 are stratified by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics, such as age, gender, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status.	See factor 1.	Use ADM standard and custom queries to capture race, ethnicity, and other indicators of vulnerablility. Use Health Maintenance and Disease Management to track patients.			
6	**B**		**Measure Resource Use and Care Coordination**	**At least annually, the practice measures or receives quantitative data on:**					
6	B	1	At least two measures related to care coordination.	A care coordination measure assesses "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care." (AHRQ).	Reports showing performance that compare "better" or "worse" results on specific metrics and may include aggregated information.	Use the APR Referral Follow-up Worklist, incorporate CCDs into the patient's EMR, share data across the EHR, and use ADT Notices in PWM.	*SQL Report for CMS 50		
6	B	2	At least two utilization measures affecting health care costs.	The practice uses resources judiciously to help patients receive appropriate care. The types of measures monitored for this factor are intended to help practices understand how efficiently they provide care, and may include ER visits, potentially avoidable hospitalizations and hospital readmissions, redundant imaging or lab tests, prescribing generic medications vs. brand name medications and number of specialist referrals.	Reports showing performance that compare "better" or "worse" results on specific metrics and may include aggregated information. For Renewal Surveys, the practice provides reports showing that it has measured annually for two years (current year and previous year).	Use SQL Clinical Quality Measure workflows to capture this information.	*SQL Report for CMS 129, 146, 154, and 166		
6	**C**		**Measure Patient/Family Experience**	**At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.**	**The practice uses survey feedback to inform its quality improvement activities. The patient survey may be telephone, paper or electronic, and must represent the practice population (including all relevant subpopulations).**				
6	C	1	The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: access, communication, coordination, whole person care/self-management support.	The practice or practice designee surveys patients to assess patient/family experience. The survey includes questions related to at least three of the following categories: access, communication with the practice, clinicians and staff, coordination of care, whole-person care/self-management support.	Reports with summarized results of feedback of patient feedback.	N/A	N/A		
6	C	2	The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool.	The practice uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH Survey Tool to collect patient experience data.	See factor 1.	N/A	N/A		
6	C	3	The practice obtains feedback on experiences of vulnerable patient groups.	The practice uses a survey or another method to assess quality of care for its vulnerable subgroups.	See factor 1.	N/A	N/A		
6	C	4	The practice obtains feedback from patients/families through qualitative means.	Qualitative feedback methods such as focus groups, individual interviews, patient walkthrough and suggestion boxes may be used.	See factor 1.	N/A	N/A		

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6	**D**		**Implement Continuous Quality Improvement (MUST-PASS)**	**The practice uses an ongoing quality improvement process to:**					**Must-Pass element**
6	D	1	Set goals and analyze at least three clinical quality measures from Element A.	The practice sets goals and acts to improve performance, based on clinical quality measures (Element A), resource and care coordination measures (Element B) and patient experience measures (Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.	Report showing how the practice meets each factor or the completed PCMH Quality Measurement and Improvement Worksheet.	N/A	*SQL Clinical Quality Measure Reports		
6	D	2	Act to improve at least three clinical quality measures from Element A.	See factor 1.	See factor 1.	N/A	*SQL Clinical Quality Measure Reports		
6	D	3	Set goals and analyze at least one measure from Element B.	See factor 1.	See factor 1.	N/A	*SQL Clinical Quality Measure Reports		
6	D	4	Act to improve at least one measure from Element B.	See factor 1.	See factor 1.	N/A	*SQL Clinical Quality Measure Reports		
6	D	5	Set goals and analyze at least one patient experience measure from Element C.	See factor 1.	See factor 1.	N/A	N/A		
6	D	6	Act to improve at least one patient experience measure from Element C.	See factor 1.	See factor 1.	N/A	N/A		
6	D	7	Set goals and address at least one identified disparity in care/service for identified vulnerable populations.	The practice identifies areas of disparity among vulnerable populations and makes a comparison to the general population. The practice then sets goals, and acts to improve performance in these areas.	See factor 1.	N/A			
6	**E**		**Demonstrate Continuous Quality Improvement**	**The practice demonstrates continuous quality improvement by:**					
6	E	1	Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.	The practice demonstrates that it collects clinical quality (Element A), resource use (Element B) or patient experience (Element C) performance data and assesses the results over time. The practice is not required to demonstrate improvement in this factor.	Reports or a completed PCMH Quality Measurement and Improvement Worksheet that shows how the practice meets the requirements.	Use SQL Clinical Quality Measure reports to collect data.	*SQL Clinical Quality Measure Reports		
6	E	2	Achieving improved performance on at least two clinical quality measures.	The practice demonstrates that its performance on the measures has improved over time, based on its assessment.	See factor 1.	Use SQL Clinical Quality Measure reports to collect data.	*SQL Clinical Quality Measure Reports		
6	E	3	Achieving improved performance on one utilization or care coordination measure.	The practice demonstrates that its performance on the measures has improved over time, based on its assessment.	See factor 1.	Use SQL Clinical Quality Measure reports to collect data.	*SQL Clinical Quality Measure Reports		
6	E	4	Achieving improved performance on at least one patient experience measure.	The practice demonstrates that its performance on the measures has improved over time, based on its assessment.	See factor 1.	N/A	N/A		
6	**F**		**Report Performance**	**The practice produces performance data reports using measures from Elements A, B and C and shares:**					
6	F	1	Individual clinician performance results with the practice.	The practice provides individual clinician reports to clinicians and practice staff.	Reports provided to clinicians and practice staff showing individual clinician performance and explaining how results are disseminated.	Use SQL Clinical Quality Measure reports to make data/results available.	SQL Clinical Quality Measure Reports		
6	F	2	Practice-level performance results with the practice.	The practice provides practice-level performance results to all clinicians and practice staff.	Reports showing practice-level performance results and explaining how results are disseminated.	Use SQL Clinical Quality Measure reports to make data/results available.			
6	F	3	Individual clinician or practice-level performance results publicly.	The practice reports site-specific or clinician data on its Web site, or data are made public by a health plan or other entity.	Example of a performance report provided to the public.	Use SQL Clinical Quality Measure reports to make data/results available.	N/A		
6	F	4	Individual clinician or practice-level performance results with patients.	The practice reports site-specific or clinician performance results to patients, or makes results available. The practice may use communication (e.g., letter, e-mail, mass mailing) to notify patients that the information is publicly available.	Example of a performance report provided to patients.	Use SQL Clinical Quality Measure reports to make data/results available.	N/A		
6	**G**		**Use Certified EHR Technology**	**The practice uses a certified EHR system.**					
6	G	1	The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.	The practice attests to using a certified EHR system and provides the CMS Certification ID number(s) of the software system (or modules) used by the practice. Since the practice may use more than one software system, all must be listed.	By entering a "yes" response in the PCMH Survey Tool, the practice attests to using a Certified Electronic Health Record and that it has been issued a CMS certification ID to perform the designated CMS Meaningful Use requirements.	Use the CHPL website to obtain the CMS Certification ID for the specific MEDITECH product you are using.	N/A		

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6	G	2	The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.	The practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies.	By entering a "yes" response in the PCMH Survey Tool, the practice attests to conducting the required security risk analysis of its certified EHR system (or modules), implementing security updates as necessary and correcting identified security deficiencies.	N/A	N/A		
6	G	3	The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.	The practice attests that it performs "successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period."	By entering a "yes" response in the PCMH Survey Tool, the practice attests to its "capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice."	Use the Syndromic Surveillance interface to fulfill this Meaningful Use measure.	N/A		
6	G	4	The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.	The practice attests that it has "successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period."	By entering a "yes" response in the PCMH Survey Tool, the practice attests to its "capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.	Use the Cancer Case Interface to fulfill this Meaningful Use measure.	N/A		
6	G	5	The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.	The practice attests that it has "successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period."	By entering a "yes" response in the PCMH Survey Tool, the practice attests to its "capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice."	Use the Specialized registry interface to fulfill this Meaningful Use measure.	N/A		
6	G	6	The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use.	The practice reports clinical quality measures to Medicare or a state (Medicaid program).	By entering a "yes" response in the PCMH Survey Tool, the practice attests that it reports clinical quality measures to Medicare or Medicaid, as required for Meaningful Use.	Use SQL CQM reports to capture data to report for Meaningful Use.	SQL Clinical Quality Measure Reports		
6	G	7	The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.	The practice attests that it has "performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful."	By entering a "yes" response in the PCMH Survey Tool, the practice attests to "its capability to submit electronic data to immunization registries or immunization information systems."	Use the Immunizations Interface to fulfill this Meaningful Use Measure.	N/A		
6	G	8	The practice has access to a health information exchange.	The practice attests that it has access to and can view information in a health information exchange (HIE).	By entering a "yes" response in the PCMH Survey Tool, the practice attests to its capability to view HIE information. The practice provides the name(s) of the HIE.	N/A	N/A		
6	G	9	The practice has bidirectional exchange with a health information exchange.	The practice attests that it has bidirectional communication (i.e., can send and receive information) with an HIE.	By entering a "yes" response in the PCMH Survey Tool, the practice attests to its capability to both send and receive information from an HIE. The practice provides the name(s) of the HIE.	Use the CCD Interface and Direct Messaging to send and receive information with an HIE.	N/A		
6	G	10	The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care.	The practice attests that it can "[use] clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference… for [more] than 10 percent of all unique patients."	By entering a "yes" response in the PCMH Survey Tool, the practice attests to "using clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference…for [more] than 10 percent of all unique patients."	Use the APR Health Maintenance and Disease Management Letters/Reports routines.	SQL Patient Reminders Report		

Additional Notes:

Must-pass elements are those that practices must achieve a score of 50 percent or higher to achieve any recognition level

Critical factors are those that must be met for practices to receive more than minimal or sometimes any points for element

* Indicates that the report calculates percentages based on individual providers. In order to calculate the percentage for the practice, provider totals must be manually combined or the report must be edited to calculate based on the practice.