Physician Practice Connections—
Patient Centered Medical Home

Getting Started

Any practice assessing its ability to achieve NCQA Physician Recognition in PPC-PCMH is taking a bold step toward aligning with the 2007 Joint Principles of the Patient-Centered Medical Home developed by the AAFP, the AAP, the ACP and the AOA. The following pages summarize the elements and provide examples of how other practices meet the requirements.

Note: *Examples are not meant to imply an endorsement of a specific software or format.*

To get started, a practice should consider the elements' "must-pass" requirements and its own electronic capabilities. This will help focus initial efforts to determine which elements to respond to first. Below are some basic guidelines and definitions.

Must-Pass Elements

There are 10 must-pass elements, identified by a yellow arrow on the element page. NCQA recommends that a practice start its evaluation by picking 5 must-pass elements it can meet with a performance level of at least 50%, at minimum. A practice that can meet 50% is well on the way to achieving Level 1 Recognition (refer *Achievement Levels*, below).

The must-pass elements are:

- PPC 1A
- PPC 1B
- PPC 2D
- PPC 2E
- PPC 3A
- PPC 4B
- PPC 6A
- PPC 7A
- PPC 8A
- PPC 8C

Recognition Levels

There are three levels of recognition in PPC.

Level	Points Required	Number of Must-Pass Elements Met With a Performance Level of ≥50%
1	25-49	5 of 10
2	50–74	10 of 10
3	≥75	10 of 10

Electronic Capabilities (*"IT Required"* in the PPC-PCMH Standards & Guidelines)

These elements were developed with a small practice in mind and do not exclude practices with minimal electronic capabilities. Electronic capabilities are defined for each element by the following three categories.

1. **LIMITED:** Paper-based or basic (mostly administrative; for example, scheduling, claims) electronic system
2. **SOME:** Electronic system for clinical functions
3. **FULLY INTEGRATED:** Electronic system with connectivity or interoperability with other systems

More than half the elements fall within the Limited Electronic Capabilities category. The practice can focus its efforts on areas where it is most likely to meet requirements with their current IT resource use.

ADDITIONAL RESOURCES

American College of Physicians PCMH page:
http://www.acponline.org/running_practice/pcmh/

American Academy of Family Physicians PCMH page:
http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html

American Academy of Pediatrics Medical Home Resource page:
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NCQA's PPC-PCMH Home Page: www.ncqa.org/ppcpcmh.aspx

ORDER PPC-PCMH Standards and Survey Tool: www.ncqa.org/ppcpubs.aspx

NCQA Customer Support: customersupport@ncqa.org

This project was sponsored by a grant from Pfizer Inc.

Physician Practice Connections—Patient Centered Medical Home

ELEMENT 1A: Access and communication processes

4 pts

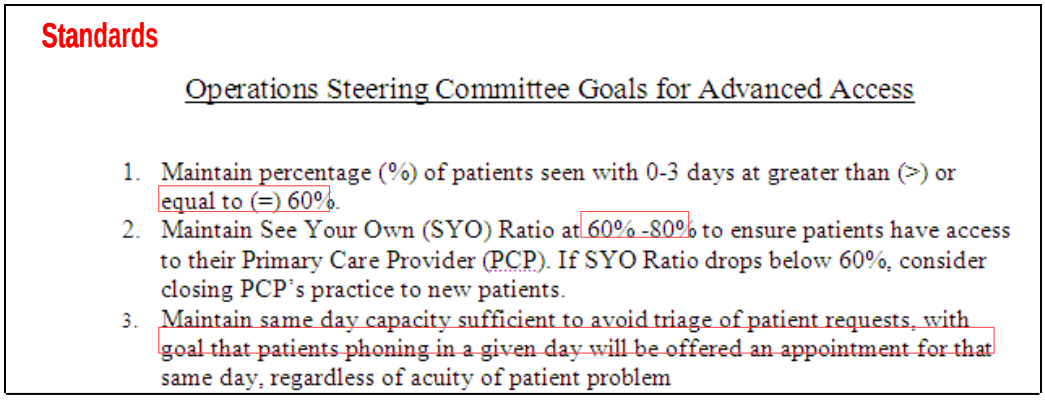
LIMITED
Electronic Systems

MUST PASS

The practice has written processes for scheduling appointments and communicating with patients.

The practice should have a written process that clearly communicates its scheduling policies. Policies should reflect how the practice accommodates patient needs and medical conditions, patient access to after-hours care and type of communication patients can expect with the practice's physician and staff. The element's intent is that written policies offer patients timely access to care, same-day response to phone inquiries, expanded visit hours and coordination of care between the physician's practice and other clinicians.

EXAMPLE* Documentation



Standards

Operations Steering Committee Goals for Advanced Access

1. Maintain percentage (%) of patients seen with 0-3 days at greater than (>) or equal to (=) 60%.
2. Maintain See Your Own (SYO) Ratio at 60% -80% to ensure patients have access to their Primary Care Provider (PCP). If SYO Ratio drops below 60%, consider closing PCP's practice to new patients.
3. Maintain same day capacity sufficient to avoid triage of patient requests, with goal that patients phoning in a given day will be offered an appointment for that same day, regardless of acuity of patient problem

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ELEMENT 1B: Access and communication results

5 pts

LIMITED
Electronic Systems

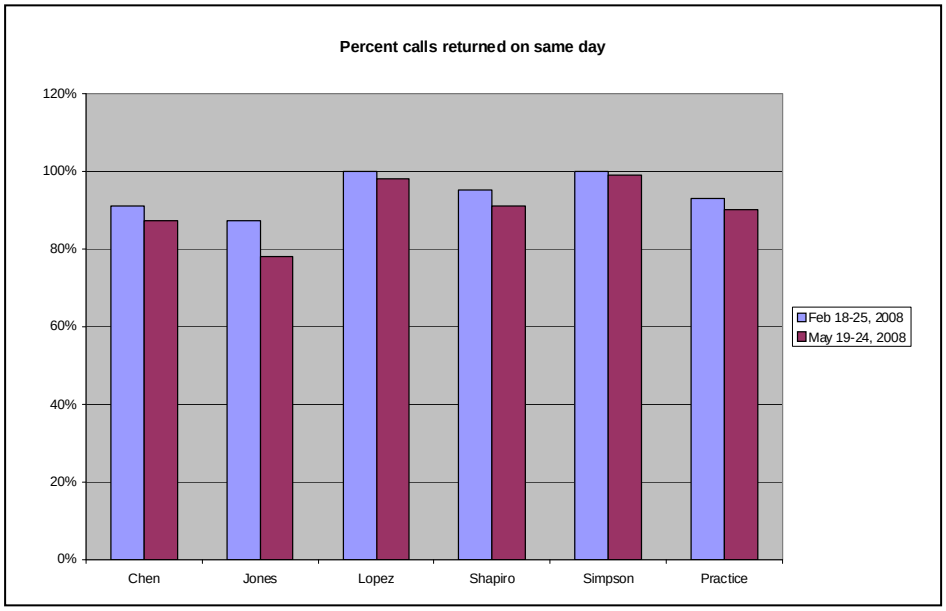
MUST PASS

The practice has data showing that it meets the standards in PPC1A for scheduling and communicating with patients.

The goal of this element is to ensure that the practice effectively implements the processes it defined in PPC 1A for patient scheduling and communication. A practice should demonstrate that it evaluates the processes and meets process goals in its written patient access and communication policies.

TIP: The practice must measure results of communication and access policy implementation—tracking reports showing same-day appointments, telephone response times for a specific time period, average time for returning after-hours phone calls, use of language services.

EXAMPLE* Documentation



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ELEMENT 2A: Basic system for managing patient data

2 pts

LIMITED
Electronic Systems

The practice organizes patient-population data using an electronic system that includes searchable information.

The practice must collect basic patient information in its electronic system and be able to conduct a search by the identified items. The practice reports on the percentage of its patient population from whom the information is collected (e.g., information on 15 items for 75% of the patient population).

TIP: To demonstrate its system for managing patient data, the practice provides a report from the electronic system showing the number of items for a specified percentage of patients.

EXAMPLE* Documentation

	A	B	C	D	E
	PPC 2 - Element A				
	Total number of patients seen at least once in last 3 months				24,860
		Data Elements	# of times used	%	
1		Name	24,860	100.00%	
2		Birthdate	24,859	100.00%	
3		Gender	24,859	100.00%	
4		Marital Status	19,565	78.70%	
5		Language	22,916	92.18%	
6		Race/Ethnicity	822	3.31%	
7		Address	24,860	100.00%	
8		Telephone	24,841	99.92%	
9		Email	3,678	14.79%	
10		Internal ID	24,860	100.00%	
11		External ID	24,860	100.00%	
12		Emergency contact	9,605	38.64%	
13		Current and past diagnoses	24,860	100.00%	
14		Dates of previous clinical visits	24,860	100.00%	
15		billing codes for services	24,860	100.00%	

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ELEMENT 2B: Electronic system for clinical data

3 pts

SOME
Electronic Systems

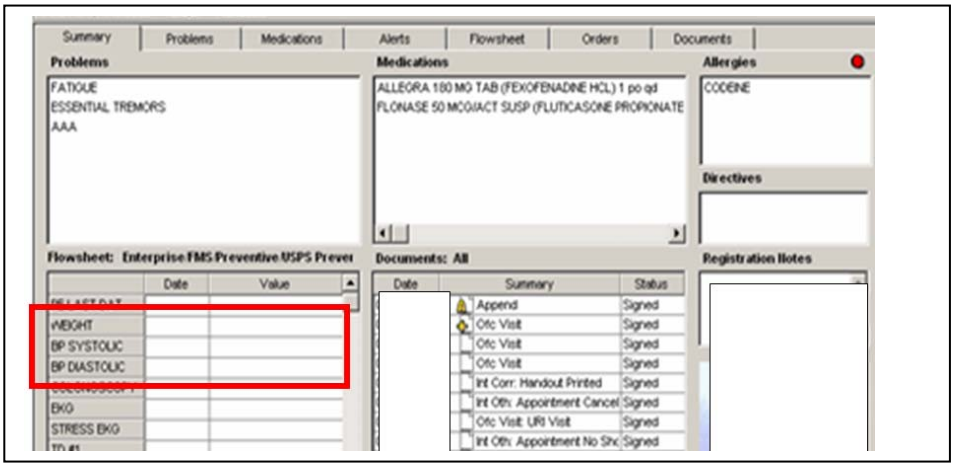
The practice's data system includes searchable clinical patient information that is used to manage patient care.

This element evaluates the practice's ability to collect clinical patient information in searchable data fields. The practice should be able to create internal reports for these 11 items.

1. Status of age-appropriate preventive services
2. Allergies and adverse reactions
3. Blood pressure
4. Height
5. Weight
6. BMI calculated
7. Lab results
8. Presence of imaging results
9. Presence of pathology results
10. Presence of advance directives
11. Head circumference for patients 2 years or younger

TIP: The practice must demonstrate the searchable information fields it uses to manage patient care. The system may be a registry or an electronic health record that allows the practice to identify groups of patients by clinical element; for example, patients with a BMI ≥30.

EXAMPLE* Documentation



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ELEMENT 2C: Use of electronic clinical data

3 pts

SOME
Electronic Systems

The practice uses the data fields listed in PPC 2B consistently in patient records.

This element evaluates the practice's ability to demonstrate its use of an electronic registry, practice management system or other electronic system. The practice must run reports on specific data collected from patients and stored in its electronic system. If it does not have an electronic system, the practice can pass this element by pulling a sample of patient medical records and entering the data in an NCQA Medical Record Review Workbook.

EXAMPLE* Documentation

Report of Percent of Patients Seen 7/1/06 to 9/30/06 who have Clinical Data Entered in Fields

Element Number	Description	Numerator	Denominator	Percent
2B1	Status of preventive services	85622	92685	92%
2B2	Allergies and adverse reactions	52711	92685	57%
2B3	Blood pressure	80568	92685	87%
2B4	Height	75243	92685	81%
2B5	Weight	85594	92685	92%
2B6	BMI calculated	65524	92685	71%
2B7	Lab test results			100%
2B8	presence of imaging results			100%
2B9	presence of pathology results			100%
2B10	presence or absence of advance directives	6462	92685	7%

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ELEMENT 2D: Organizing clinical data

6 pts

LIMITED
Electronic Systems

MUST PASS

The practice uses electronic or paper-based charting tools to organize and document clinical information in the medical record.

Charting tools enable practices to consistently document clinical information, such as updated problem lists; lists of OTC and prescribed medications; and developmental and growth charts. Tools prompt clinicians to document specific clinical information.

EXAMPLE* Documentation

Patient Number	Clinically Important Condition	Problem Lists?	OTC Medication Lists?	Prescribed Medication Lists?	Risk Factor Templates?	Progress Notes Templates?	Total Number of Charting Tools Used
		2 D - Charting Tools					
1	diabetes	yes	Not Used	Yes	Not Used	Yes	3
2	hypertension	yes		Yes		Yes	3
3	diabetes	yes		Yes		Yes	3
4	diabetes	yes		Yes		Yes	3
5	hyperlipidemia	yes		Yes		Yes	3
6	hypertension	yes		Yes		Yes	3
7	hypertension	yes		Yes		Yes	3
28	diabetes	yes		Yes		Yes	3
30	hyperlipidemia	yes		Yes		Yes	3
31	diabetes	yes		Yes		Yes	3
32	diabetes	yes		Yes		Yes	3
33	hyperlipidemia	yes		Yes		Yes	3
34	hypertension	yes		Yes		Yes	3
35	diabetes	yes		Yes		Yes	3
36	hyperlipidemia	yes		Yes		Yes	3
Patient Files (Yes)							36
Patient Files (No)							0

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ELEMENT 2E: Identifying important conditions
4 pts

LIMITED
Electronic Systems

MUST PASS

The practice uses an electronic or paper-based system to identify the following in the practice's patient population:

- **Most frequently seen diagnoses**
- **Most important risk factors**
- **Three clinically important conditions**

The practice identifies important conditions for its patient population and uses the information to manage specific groups of patients. Practices may use a practice management system, a billing system or an electronic health record to identify the conditions.

TIP: The practice must produce reports to show how conditions were selected.

EXAMPLE* Documentation

Visit Diagnosis Code	ICD9 Code	Diagnosis Description	Number of Patients	Category
272.4	272.4	HYPERLIPIDEMIA NEC/NOS	85875	Hyperlipid
401.9	401.9	HYPERTENSION NOS	58755	HTN
250.00	250.00	DM W/O COMPL TYPE II/UNSPEC	38018	DIABETES
477.9	477.9	ALLERGIC RHINITIS NOS	27181	Allergies
244.9	244.9	HYPOTHYROIDISM NOS	24533	Hypothyroid
477.8	477.8	ALLERGIC RHINITIS NEC	19375	Allergies
311	311	DEPRESSION	18961	Depression
401.1	401.1	BENIGN HYPERTENSION	18508	HTN
V58.61	V58.61	LONGTERM [CURRENT] USE OF ANTICOAGULANTS	18351	Anticoag
427.31	427.31	ATRIAL FIBRILLATION	17990	Afib
174.9	174.9	MALIG NEO BREAST FEMALE NOS	16723	CancerBreast
493.90	493.90	ASTHMA, UNSPEC, UNSPEC	15513	ASTHMA
414.00	414.00	CORONARY ATHEROSCLEROSIS UNSPECIFIED	11513	CVD
278.00	278.00	OBESITY, UNSPECIFIED	9644	Obesity
185	185	MALIG NEO PROSTATE	9003	CancerProstate
428.0	428.0	CONGESTIVE HEART FAILURE	6895	CHF
296.30	296.30	MAJOR DEPRESSIVE DISORDER, RECURRENT	5885	Depression
714.0	714.0	RHEUMATOID ARTHRITIS	4507	Arthritis
162.9	162.9	MALIG NEO BRONCH/LUNG NOS	3197	CancerLung
278.01	278.01	OBESITY, MORBID	3177	Obesity

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ELEMENT 2F: Use of system for population management

3 pts

SOME
Electronic Systems

The practice uses electronic information to generate patient lists and remind patients or clinicians about necessary services, such as specific medications or tests, preventive services, pre-visit planning and follow-up visits.

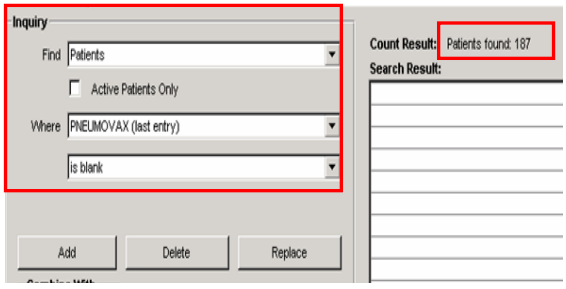
The practice should be able to manage its patient population by creating reports on the following fields.

- Demographic information
- Contact information such as zip codes
- Imaging tests
- Laboratory tests
- Prescription medications
- Over-the-counter medications
- Diagnosis or treatment codes
- Status of preventive health services and risk factors.

This element requires the practice to include the reports and show how it uses them to manage groups of patients, such as reminding patients about follow-up visits or services needed (e.g., women over 50 due for a mammogram).

EXAMPLE* Documentation

EHR Query-Patients Needing Pneunomax vaccine



Report – Patients on a Specific Medication

Patient	Medication
	Atenolol 50 MG Tablet
	Atenolol 50 MG Tablet
	Atenolol 50 MG Tablet
	Atenolol 50 MG Tablet
	Atenolol 50 MG Tablet
25	Atenolol 50 MG Tablet
	Atenolol 50 MG Tablet

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 3A: Guidelines for important conditions

3 pts

LIMITED
Electronic Systems

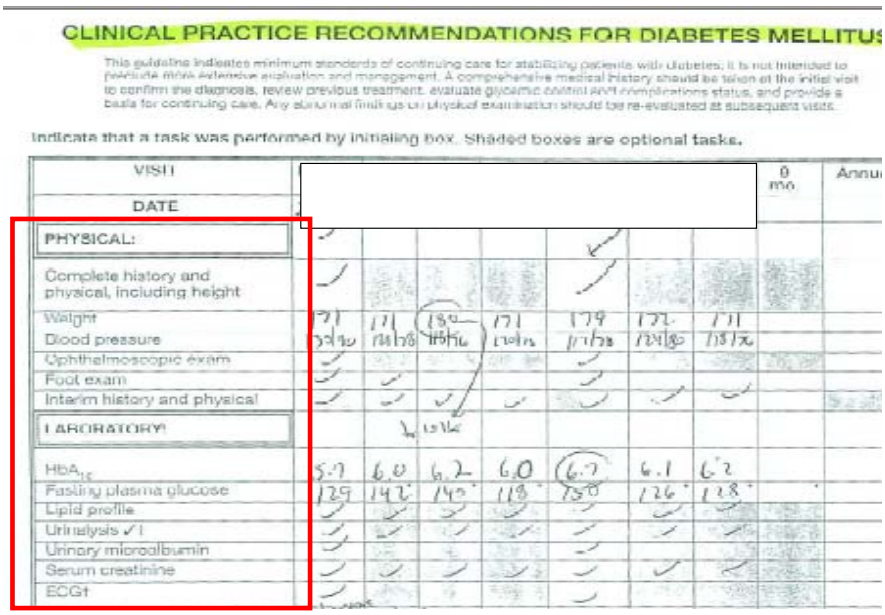
MUST PASS

The practice implements evidence-based guidelines for the three identified clinically important conditions.

This element requires practices to adopt *and* implement evidence-based diagnosis and treatment guidelines for the three clinically important conditions (Element 2E). Practices must use a paper or electronic template ("workflow organizer") to demonstrate consistent implementation of the adopted guidelines and clearly identify the source of the guidelines.

TIP: The practice shows the templates for prompting clinicians to document clinical information, in accordance with adopted guidelines, at the patient's visit. Paper-based supporting documentation includes flow sheets or templates used to document treatment plans or patient progress. Electronic supporting documentation includes screen shots of templates used to document treatment plans and patient progress.

EXAMPLE* Documentation


CLINICAL PRACTICE RECOMMENDATIONS FOR DIABETES MELLITUS

This guideline indicates minimum standards of continuing care for stabilizing patients with diabetes; it is not intended to preclude more extensive evaluation and management. A comprehensive medical history should be taken at the initial visit to confirm the diagnosis, review previous treatment, evaluate glycemic control and complications status, and provide a basis for continuing care. Any abnormal findings on physical examination should be re-evaluated at subsequent visits.

Indicate that a task was performed by initialing box. Shaded boxes are optional tasks.

VISIT								0 mo.	Annu
DATE									
PHYSICAL:	✓				✓				
Complete history and physical, including height	✓				✓				
Weight	171	171	180	171	179	172	171		
Blood pressure	130/90	128/78	118/76	120/78	117/78	124/80	118/76		
Ophthalmoscopic exam	✓				✓				
Foot exam	✓	✓			✓				
Interim history and physical	✓	✓	✓	✓	✓	✓	✓		
LABORATORY:									
HbA_{1c}	5.7	6.0	6.2	6.0	6.7	6.1	6.2		
Fasting plasma glucose	129	142	140	118	150	126	128		
Lipid profile	✓	✓	✓	✓	✓	✓	✓		
Urinalysis ✓	✓	✓	✓	✓	✓	✓	✓		
Urinary microalbumin	✓				✓				
Serum creatinine	✓	✓	✓	✓	✓	✓	✓		
ECG†	✓				✓				

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ELEMENT 3B: Preventive-service clinician reminders

4 pts

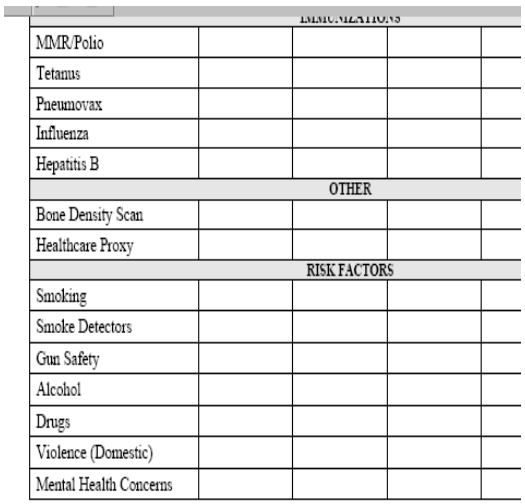
LIMITED
Electronic Systems

The practice uses guideline-based reminders to prompt physicians about a patient's preventive care needs at the time of the patient's visit.

The practice should have systems in place to alert or remind clinicians about preventive services for patients during the patient's office visit. Alerts may be paper-based or electronic prompts for clinicians to order screening tests, immunizations, risk assessments or counseling.

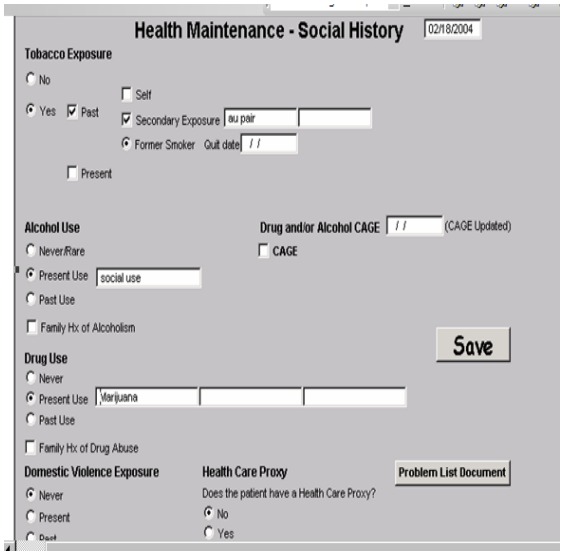
EXAMPLE* Documentation

Paper Reminder for Risk Assessments, Immunizations, Screening Tests



MMR/Polio				
Tetanus				
Pneumovax				
Influenza				
Hepatitis B				
OTHER				
Bone Density Scan				
Healthcare Proxy				
RISK FACTORS				
Smoking				
Smoke Detectors				
Gun Safety				
Alcohol				
Drugs				
Violence (Domestic)				
Mental Health Concerns				

EHR with Risk Assessment Reminders



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ELEMENT 3C: Practice organization

3 pts

LIMITED
Electronic Systems

The practice maintains a team approach to managing patient care.

A team approach includes use of nonphysician staff. Shared responsibilities are designed to maximize each team member's level of training and expertise. In small practices, roles may be designated for the physician, the nurse and existing administrative staff. Supporting documentation for this element includes protocols, job descriptions, standing orders that show how the practice involves nonphysician staff in various aspects of patient care management.

EXAMPLE* Documentation

Medication Refill Protocol

Exceptions (Route to Doctor)

- Antibiotics
- Pregnant
- Allergies/ Adverse Reactions to Medications Being Prescribed
- Any class of medication other than below

Class of meds	Cholesterol Reducing	Hypertension	HCTZ/ Diuretic For HTN	Cardiac (Digoxin and others)	Metered Dose Inhalers	Allergy (allegra, zyrtec, nasal steroids	Diabetes	GI (Nexium, Protonix, etc.)	Anti Depressant (Paxil, Prozac, etc)
Type of lab	Lipid fast CMP	BMP or CMP	BMP Q6mo	Digoxin level, potassium			HbA1c Q3mo., Lipid Q6 mo		
Visit Frequency	6 mo.	6 mo. If pt comes in regularly, otherwise 1 month and revisit	6 mo. If pt comes in regularly, otherwise 1 month and revisit	6 mo.	Check chart note for revisit; no less than every 6 mo.		3 months unless HbA21C<7, then Q 6 mo.		See chart note; minimum Q 6 mo.

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ADDITIONAL RESOURCES

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 3D: Care management of important conditions

5 pts

LIMITED
Electronic Systems

The practice demonstrates the use of various components of care management for patients with one or more of the clinically important conditions.

The practice documents care management support that physician and nonphysician staff provide to patients who have one of the three clinically important conditions (Element 2E). Using information documented in the patient record, the practice provides a report ***or*** a completed Medical Record Review Workbook, showing that clinicians provided specific components of care management: individualized care plans and treatment goals; medication review; assessment of barriers to patient goals.

EXAMPLE* Documentation

Patient Number	Clinically Important Condition	Review Medication?	Review Self-Monitored Results	Assess Treatment Goal Barriers?	Assess Medication Barriers?	Follow-Up Missed Appointments?	Review Clinical Measurement?	Complete After-Visit Follow-Up?	Total Number of Component Used
		3 D - Care Management Support Components							
1	diabetes	yes	yes	yes	no	yes	yes	yes	5
2	hypertension	yes	no	no	no	yes	yes	yes	4
3	diabetes	yes	no	no	no	yes	yes	no	3
4	diabetes	yes	yes	yes	yes	yes	yes	yes	7
5	hyperlipidemia	yes	no	no	no	yes	yes	no	3
6	hypertension	yes	yes	no	no	yes	yes	no	4
7	hypertension	yes	yes	no	no	yes	yes	yes	5
23	hyperlipidemia	yes	no	no	no	no	yes	no	2
24	hyperlipidemia	yes	no	yes	yes	yes	yes	yes	6
32	diabetes	yes	no	yes	no	yes	yes	no	4
33	hyperlipidemia	yes	no	yes	no	yes	yes	yes	5
34	hypertension	yes	yes	no	no	yes	yes	no	4
35	diabetes	yes	yes	no	yes	yes	yes	yes	6
36	hyperlipidemia	yes	yes	no	no	yes	yes	no	4
Patient Files (Yes)									11
Patient Files (No)									25
Patient Sample Size (Yes+No)									36
Percentage of Patients (Yes/Sample)									30.6%

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 3E: Continuity of care

5 pts

LIMITED
Electronic Systems

The practice coordinates care with external organizations and other physicians.

The practice identifies patients treated in inpatient and outpatient settings and contacts them after discharge to provide or coordinate follow up care. It maintains processes for coordinating care for patients who receive care management or disease management services and provides coordination for patients who receive care from other physicians.

EXAMPLE* Documentation

Date of ER Visit	Diagnosis	Follow up call	Follow up appointment
	SOB	We admitted pt	Pt has problems with providing care for his wife.
	Cath drop	Yes	no f/u necessary
	Fever dialysis pt	F/u to specialist	no f/u with us
	Injured L. Hand	no f/u necessary	
	Diarrhea,fever, vomiting	Told to go to ER	Pt told to go to Er by us
	Flu	F/u scheduled	
	Leg Bleed	F/u scheduled	
	Dialysis Pt C/p		Pt referred to pt assist for meds
	Blood Test	F/u scheduled	
	Sodium Level Dropped Ams	f/u scheduled	
	Chest Pain	Pt has been called	Not been in since

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 4A: Documenting communication needs

2 pts

LIMITED
Electronic Systems

The practice establishes a system to identify patients with unique communication needs.

This element assesses communication barriers at the point of care between clinician and patient; it requires the practice to establish a system that prompts clinicians to assess language, hearing and vision needs of each patient.

EXAMPLE* Documentation

Language Best Served In	Distinct Patient Count	Percentage
CHINESE	6.00	0.41 %
ENGLISH	936.00	63.46 %
FRENCH	2.00	0.14 %
JAPANESE	2.00	0.14 %
OTHER	21.00	1.42 %
SIGN LANGUAGE	2.00	0.14 %
SPANISH	506.00	34.31 %
Percent:		**100.00 %**
Sum:	**1,475.00**	

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 4B: Self management support

4 pts

LIMITED
Electronic Systems

MUST PASS

The practice works to facilitate self-management of care for patients with one of the three clinically important conditions.

This element assesses how a practice supports patient self-management and specifically aims to promote positive results for patients conducting self-management, through clear documentation of physician/practice communication and use of appropriate self-management options. It is not necessary for the practice to provide a self-management tool; it may simply connect the appropriate patients with the appropriate resources. Scoring is based on the percentage of patients with one of the three important conditions who documented at least three self-management elements in their record.

EXAMPLE* Documentation

Patient Number	Clinically Important Condition	Assess Preferences, Readiness to Change?	Provide Educational Resources?	Provide Self-Monitoring Tool or PHR?	Refers Patients to Support Programs ?	Refers Patients to Support Classes?	Refers patients to Other Resources ?	Total Number of Components Used
		4 B - Patient Self-Management Support						
2	hypertension		Yes	no	Yes	no	No	2
3	diabetes		Yes	no	no	no	No	1
4	diabetes		Yes	no	no	no	yes	2
5	hyperlipidemia		Yes	no	no	Yes	yes	3
6	hypertension		Yes	Yes	no	Yes	No	3
7	hypertension		Yes	no	no	Yes	No	2
23	hyperlipidemia		Yes	no	no	no	No	1
24	hyperlipidemia		Yes	no	Yes	Yes	yes	4
32	diabetes		no	no	no	Yes	No	1
33	hyperlipidemia		Yes	Yes	Yes	no	no	3
34	hypertension		Yes	Yes	no	no	No	2
35	diabetes		Yes	no	Yes	no	No	2
36	hyperlipidemia		Yes	Yes	no	Yes	No	3
Patient Files (Yes)								11
Patient Files (No)								25
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Percentage of Patients (Yes/Sample)								30.6%

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 5A: Electronic prescription writing

3 pts

SOME
Electronic Systems

The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions.

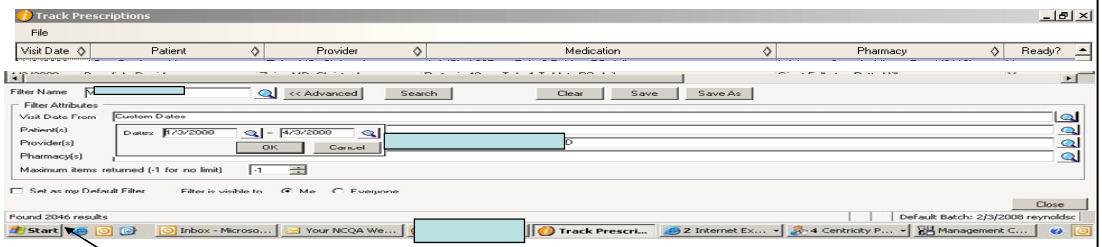
To receive full credit for this element, a practice that prescribes electronically must produce data to demonstrate the percentage of its use of one of two types of prescribing systems: a stand-alone electronic prescription writer that connects to a printer in the office or communicates directly with a pharmacy, ***or*** a system integrated with patient-specific demographic or clinical information in the electronic medical record (EMR). Partial credit is earned by a practice that has a system but has not used it, to allow time for practice-wide adoption.

EXAMPLE* Documentation

Evaluation:

Our physicians and nurses put all prescriptions in EMRs, which are linked to patient-specific demographic and clinical data. Note the screen shot that denotes the number of prescriptions for our physicians in the last three months (2,046) and the report of the number of patients seen during that same time period (2,482).

We propose that this represents a percentage between 75% and 100%, understanding that one prescription does not mean one patient.



2046 prescriptions provides the numerator to determine the percentage. The practice provided another report showing the summary of the 2482 patients seen during the same period to provide the denominator

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 5B: Prescribing decision support—safety

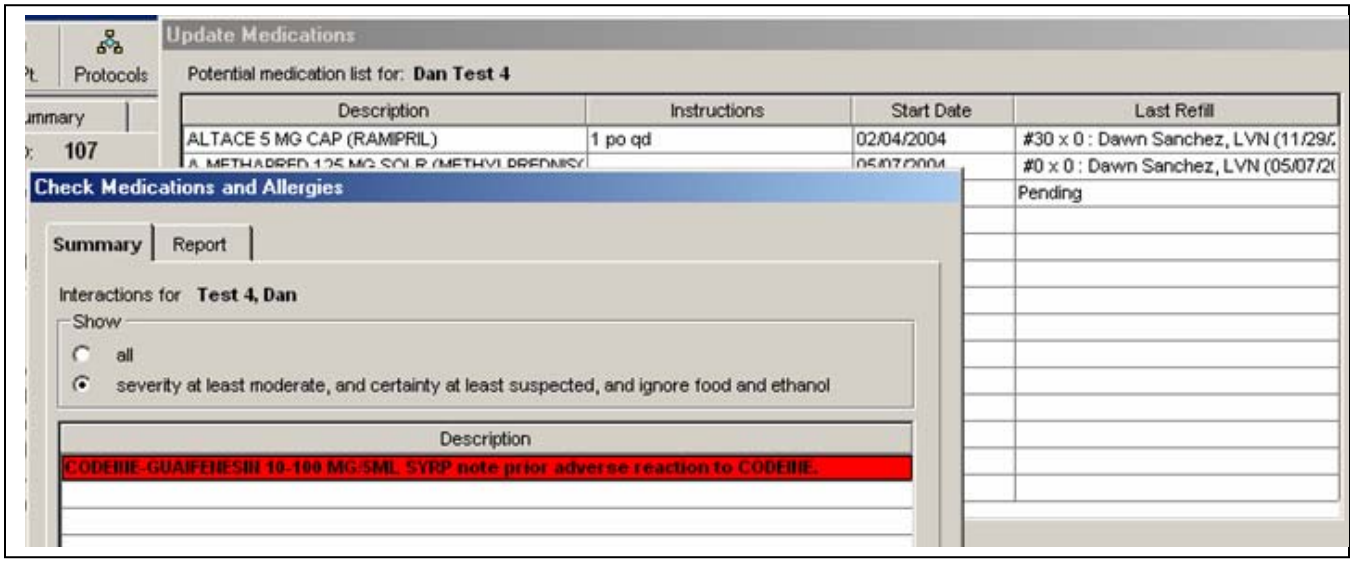
3 pts

SOME
Electronic Systems

The practice seeks to reduce medical errors and improve efficiency by using drug safety alerts when prescribing.

When a clinician uses an electronic prescription writing tool, it is important that described safety reference information is available at the point of care; for example, alerts for drug-drug interactions, drug-disease interactions, appropriate dosing and drug duplication. This element evaluates the use of such safety alerts and the number and type of alerts built into the system.

EXAMPLE* Documentation



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Physician Practice Connections—Patient Centered Medical Home

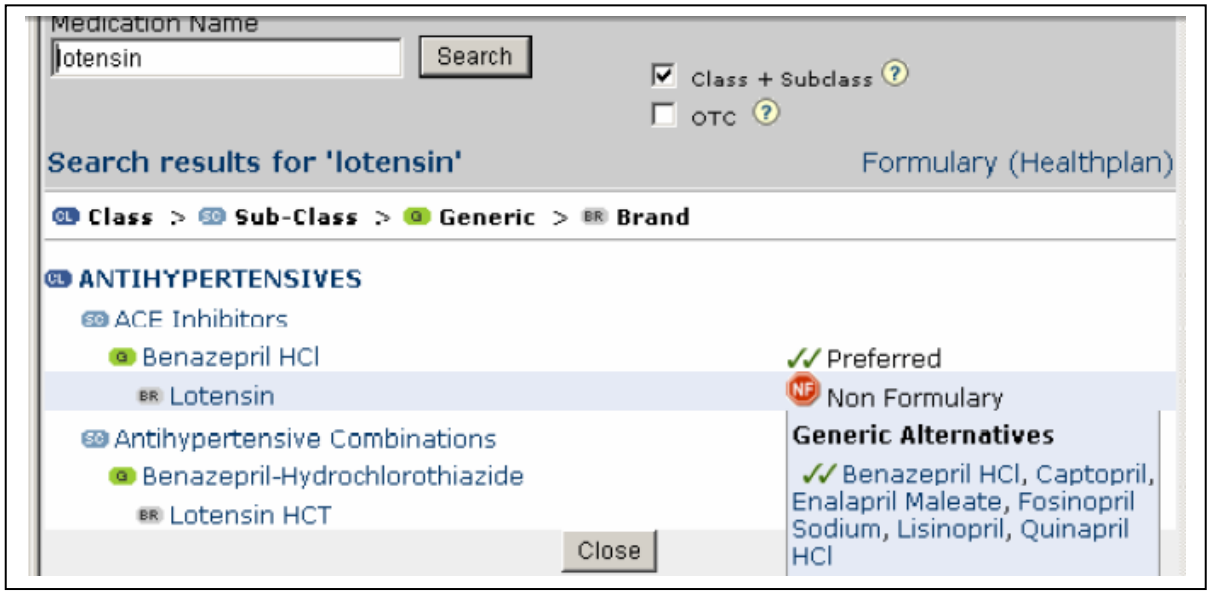
ELEMENT 5C: Prescribing decision support—efficiency
2 pts

SOME
Electronic Systems

The practice seeks to improve efficiency by using cost information when prescribing.

Each practice that has electronic prescribing may demonstrate one of two methods for cost-effective prescribing: general automatic alerts for medication choices, including generics, ***or*** a connection to payer-specific formularies that automatically alert the clinician to alternative drugs, including generics, built into the electronic prescribing tool. Partial credit is earned by a practice that has a system but has not used it, to allow time for practice-wide adoption.

EXAMPLE* Documentation



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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 6A: Test tracking and follow-up
7 pts

LIMITED
Electronic Systems

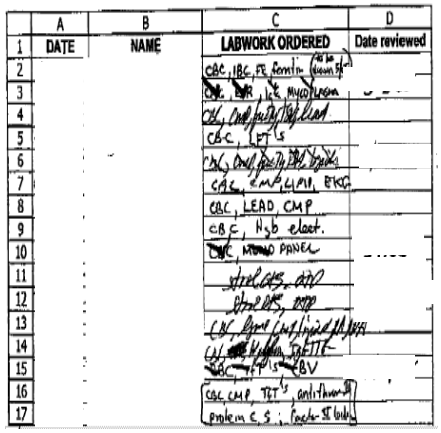
MUST PASS

The practice works to improve effectiveness of care by managing the timely receipt of information on all tests and results.

As a medical home, a practice must demonstrate that it communicates test results with patients. To demonstrate that it does this appropriately, the practice should document a system for following imaging or laboratory test orders, receipt of results by the ordering clinician, overdue orders and patient follow-up. All normal results should be communicated to the patient and abnormal results flagged for follow-up. The practice does not meet the intent of the element if it waits until a patient's next visit to communicate results.

EXAMPLE* Documentation

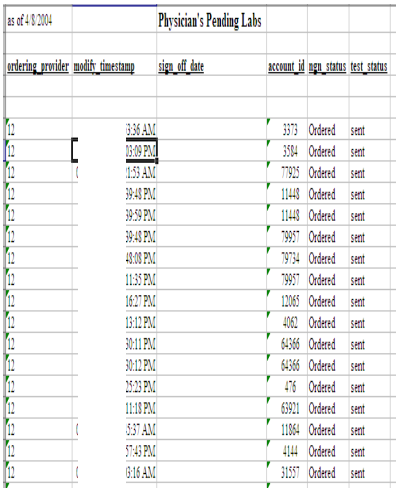
Manual Log



LAB FLOW SHEET

	A	B	C	D
1	DATE	NAME	LABWORK ORDERED	Date reviewed
2			CBC, IBC, FE, ferritin, vitamin B12	
3			CBC, LFT's, MYOGLOBIN	
4			CBC, CMP, TSH, Lipid	
5			CBC, LFT's	
6			CBC, CMP, TSH, Lipids	
7			CBC, EMB, LIPID, EKG	
8			CBC, LEAD, CMP	
9			CBC, Hgb elect.	
10			CBC, MYOGLOBIN	
11			Stool CBC, OVP	
12			Stool CBC, OVP	
13			CBC, Lipid, CMP, Lipid, HbA1C	
14			CBC, Hgb elect, FERRITIN	
15			CBC, LFT's, FBV	
16			CBC, CMP, TSH's, anti-thrombin III	
17			CBC, CMP, TSH's, anti-thrombin III, Lipids, C.S.; Lipids-SL Urine	

Spreadsheet



as of 4/8/2004		Physician's Pending Labs			
ordering_provider	modify_timestamp	sign_off_date	account_id	ngn_status	test_status
12	8:36 AM		3373	Ordered	sent
12	13:09 PM		3384	Ordered	sent
12	11:53 AM		77925	Ordered	sent
12	19:48 PM		11448	Ordered	sent
12	19:59 PM		11448	Ordered	sent
12	19:48 PM		78957	Ordered	sent
12	18:08 PM		79734	Ordered	sent
12	11:35 PM		78957	Ordered	sent
12	16:27 PM		12065	Ordered	sent
12	13:12 PM		4062	Ordered	sent
12	10:11 PM		64366	Ordered	sent
12	10:12 PM		64366	Ordered	sent
12	25:23 PM		476	Ordered	sent
12	11:18 PM		63921	Ordered	sent
12	5:37 AM		11064	Ordered	sent
12	17:43 PM		4144	Ordered	sent
12	9:16 AM		31557	Ordered	sent

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 6B: Electronic system for managing tests

6 pts

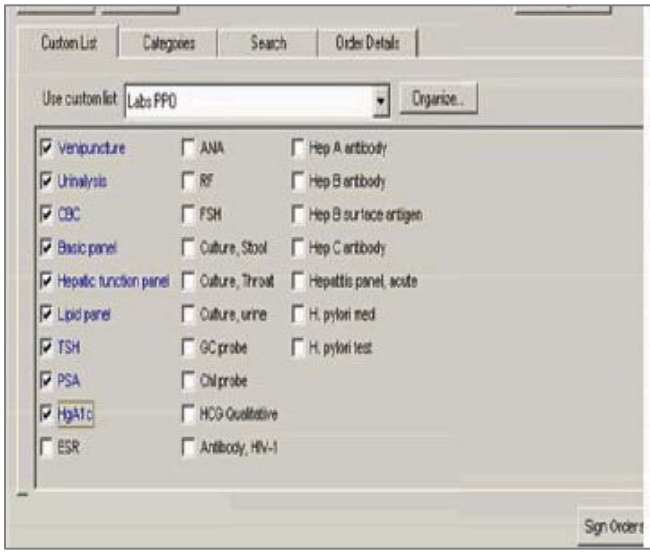
FULLY INTEGRATED
Electronic Systems

The practice can order and view lab test and imaging results electronically, with electronic alerts.

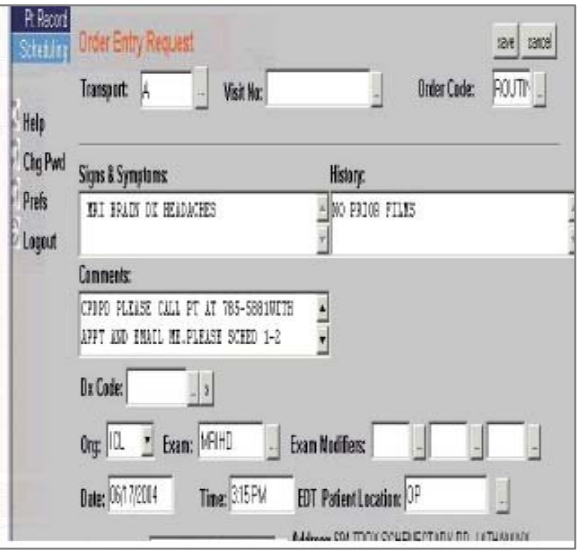
Practices earn points by maintaining interoperable systems that communicate with laboratory and imagining facilities to order tests, view results and manage alerts. Electronic system capabilities allow a practice to optimize its role as active coordinator of patient care.

EXAMPLE* Screen shots from EMR

Laboratory Test Order Screen



Radiology Test Order Screen



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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 7A: Referral tracking

4 pts

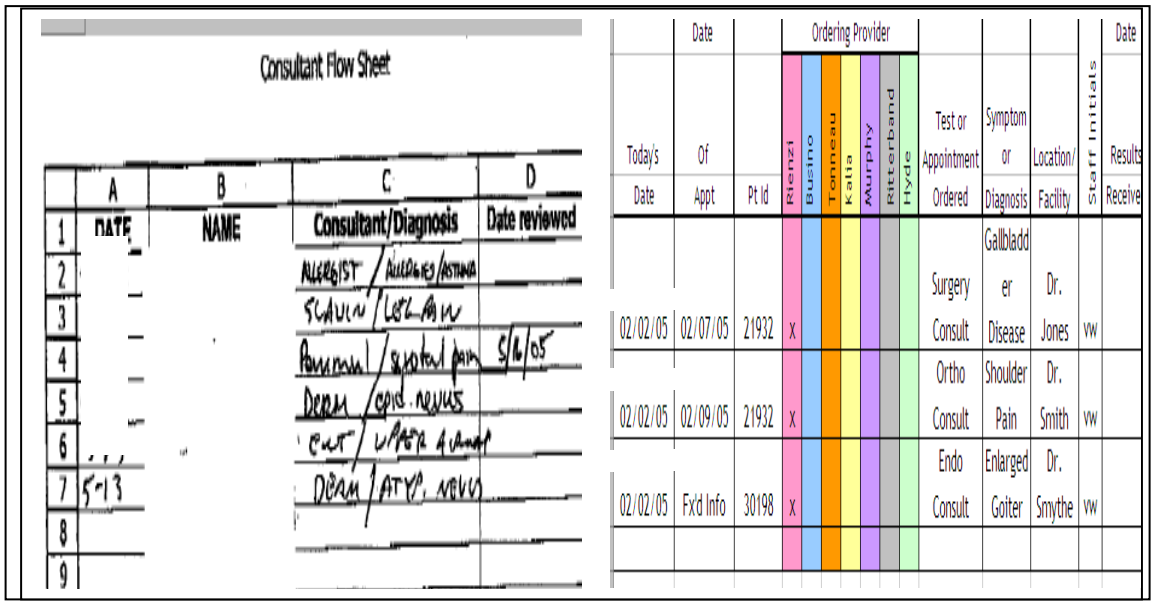
LIMITED
Electronic Systems

MUST PASS

The practice seeks to improve effectiveness, timeliness and coordination of care by following through on critical consultations with other practitioners.

When a physician orders a referral for a patient, it is important to have a system in place to track the status of the referral until the results are returned to the originating physician for evaluation—especially when the referral is critical to a patient's care. This standard looks for a tracking system for critical referrals that note the origin, tracking status and administrative and clinical details of a referral.

EXAMPLE* Documentation



Consultant Flow Sheet

	A	B	C	D
1	DATE	NAME	Consultant/Diagnosis	Date reviewed
2			ALLERGIST / ALLERGIES/ASTHMA	
3			SLAVIN / LEG PAIN	
4			Pommul / scrotal pain	5/6/05
5			DERM / epid. nevus	
6			ENT / UPPER AIRWAY	
7	5-13		DERM / ATYP. NEVUS	
8				
9				

Today's Date	Date Of Appt	Pt Id	Ordering Provider: Rienzi	Busino	Tonneau	Kalia	Murphy	Ritterband	Hyde	Test or Appointment Ordered	Symptom or Diagnosis	Location/ Facility	Staff Initials	Date Results Receive
02/02/05	02/07/05	21932	x							Surgery Consult	Gallbladder Disease	Dr. Jones	vw	
02/02/05	02/09/05	21932	x							Ortho Consult	Shoulder Pain	Dr. Smith	vw	
02/02/05	Fx'd Info	30198	x							Endo Consult	Enlarged Goiter	Dr. Smythe	vw	

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 8A: Measures of performance

3 pts

LIMITED
Electronic Systems

MUST PASS

The practice measures or receives performance data by physician or across the practice regarding:

- **Clinical process**
- **Clinical outcomes**
- **Service data**
- **Patient safety**

The practice must demonstrate that it measures two of the four types of performance by individual physician or by practice. It receives credit for NCQA Diabetes Physician Recognition (DPRP) or Heart Stroke Recognition (HSRP) for clinical process and clinical outcomes.

TIP:
Reports should reflect care for all patients, not just patients covered by one payer.

EXAMPLE* Documentation

CAHP's Patient Satisfaction Report

2004 NCQA/CAHPS Survey Results
Composite Scores & Rating Measures

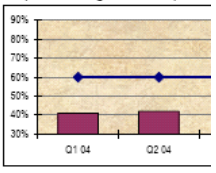
Total Respondents	421	217
Composite/Attribute/Rating Item		
Rating of Health Care	86.7%	82.5%
Rating of Personal Doctor	77.6%	77.8%
Rating of Specialist	85.8%	77.3%
Getting Needed Care	86.0%	82.0%
Getting Care Quickly	82.7%	78.0%
How Well Doctors Communicate	94.7%	90.8%
Courteous and Helpful Office Staff	95.1%	93.5%
Rating of Health Plan	83.9%	79.3%
Customer Service	85.3%	83.6%
Claims Processing	93.2%	81.8%

Clinical Performance Report

7. Control of lipids in diabetic patients

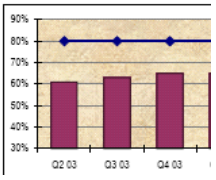
a. Percentage of patients with LDL <100 (desired range of control)

	Actual	Target
Q1 04	41%	60%
Q2 04	42%	60%
Q3 04	44%	60%
Q4 04	45%	60%
Q1 05	45%	60%
Q2 05		60%
Q3 05		60%
Q4 05		60%



b. Percentage of patients with LDL <130 (minimum desired range of con

	Actual	Target
Q2 03	61%	80%
Q3 03	63%	80%
Q4 03	65%	80%
Q1 04	65%	80%
Q2 04	64%	80%
Q3 04	65%	80%
Q4 04	66%	80%
Q1 05	65%	80%



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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 8B: Patient experience data

3 pts

LIMITED
Electronic Systems

The practice collects data on patient experience with:

- **Access to care**
- **Quality of physician communication**
- **Patient/family confidence in self-care**
- **Patient/family satisfaction with care**

Practices may collect patient experience information by phone or through a paper or electronic survey. Practices should be able to provide a summary of the survey information, not just a blank questionnaire or survey form.

EXAMPLE* Documentation

Results of Patient Phone Satisfaction Study

66 patients Surveyed

5 minutes Waiting	6 Minutes Waiting	3 Minutes Waiting	2 Minutes Waiting
7% surveyed	10% surveyed	62% surveyed	21% surveyed

Results of Patient Time from Check In to Exam Room

42 Patients Tracked

Patients taken to exam room before Scheduled time	5 minutes from sign in to exam	6 Minutes and more from sign in to exam room	
24% of tracked	34% of tracked	42% of tracked	

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 8C: Reporting to physicians

3 pts

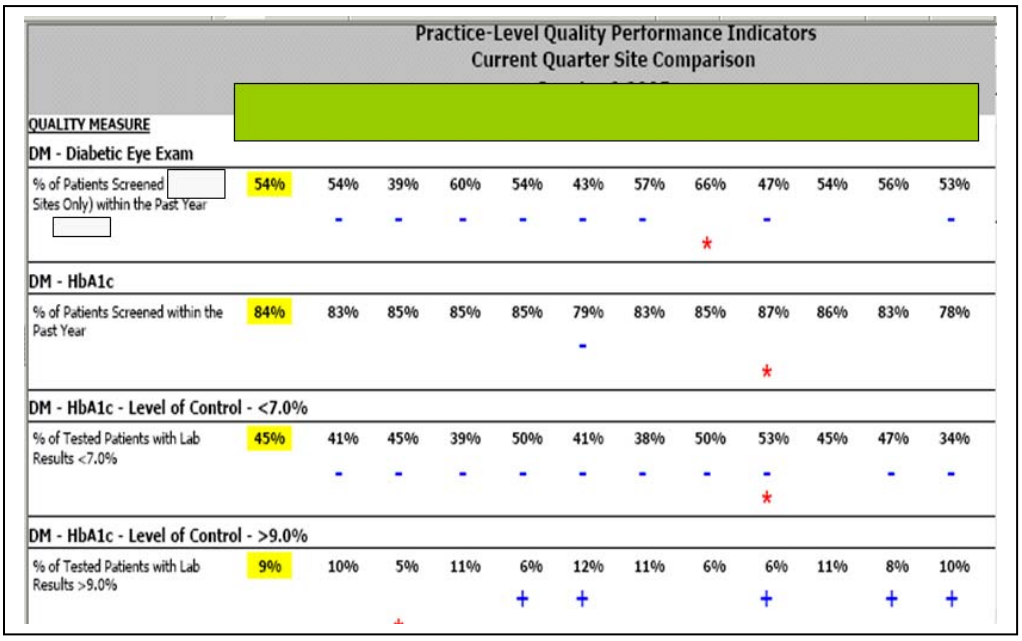
LIMITED
Electronic Systems

MUST PASS

The practice reports on its performance on the factors in Elements 8A and 8B (measures of performance and patient experience data).

This element requires the practice to give physicians and staff reports of the data collected in 8A and 8B, reported by the practice and by individual physician. Data may be from an affiliated group, such as a larger medical group, practice association or health plan, but it must reflect care provided for all patients.

EXAMPLE* Documentation



Practice-Level Quality Performance Indicators
Current Quarter Site Comparison

QUALITY MEASURE												
DM - Diabetic Eye Exam												
% of Patients Screened Sites Only) within the Past Year	54%	54%	39%	60%	54%	43%	57%	66%	47%	54%	56%	53%
DM - HbA1c												
% of Patients Screened within the Past Year	84%	83%	85%	85%	85%	79%	83%	85%	87%	86%	83%	78%
DM - HbA1c - Level of Control - <7.0%												
% of Tested Patients with Lab Results <7.0%	45%	41%	45%	39%	50%	41%	38%	50%	53%	45%	47%	34%
DM - HbA1c - Level of Control - >9.0%												
% of Tested Patients with Lab Results >9.0%	9%	10%	5%	11%	6%	12%	11%	6%	6%	11%	8%	10%

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 8D: Setting goals and taking action

3 pts

LIMITED
Electronic Systems

The practice uses performance data to:

- **Set goals based on measurement results referenced in Elements 8A and 8B**
- **Where necessary, act to improve performance of individual physicians or of the practice as a whole**

This element requires the practice to use clinical evaluation (8A) and patient experience (8B) data to set goals for improvement and to show that it is working to implement the goals through periodic reassessment. Improvement goals and activities may be practice-wide or by individual physician.

EXAMPLE* Documentation

A	B	C	D	E	F
Areas for Analysis	Data Source or Measure	Opportunity Identified	Current Performance	Performance Goal	Action Taken and Date of Implementation
To complete table –	*List at least one data source or measure for each opportunity*	*List at least one opportunity*	*List current rate of performance*	*List at least one goal for each opportunity*	*List at least one activity for each opportunity and the start date of the activity*
Care Management					
	Follow up rate of Diabetics	We have found a direct correlation between the number of follow up visits and the control of the diabetic patient. The more frequent the visits the better the control.	Current recall rate for Diabetics is 49.3%	75% recall rate to start, with the further goal of increasing on a regular basis	Using our Pro Care Protocol, we are monitoring the recall rate at this practice and supplying the practice with the Physician Action Forms that identify the patients that are due/overdue for their follow up appointments. We also have asked the reception staff to make follow up appointments at

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 8E: Reporting standardized measures

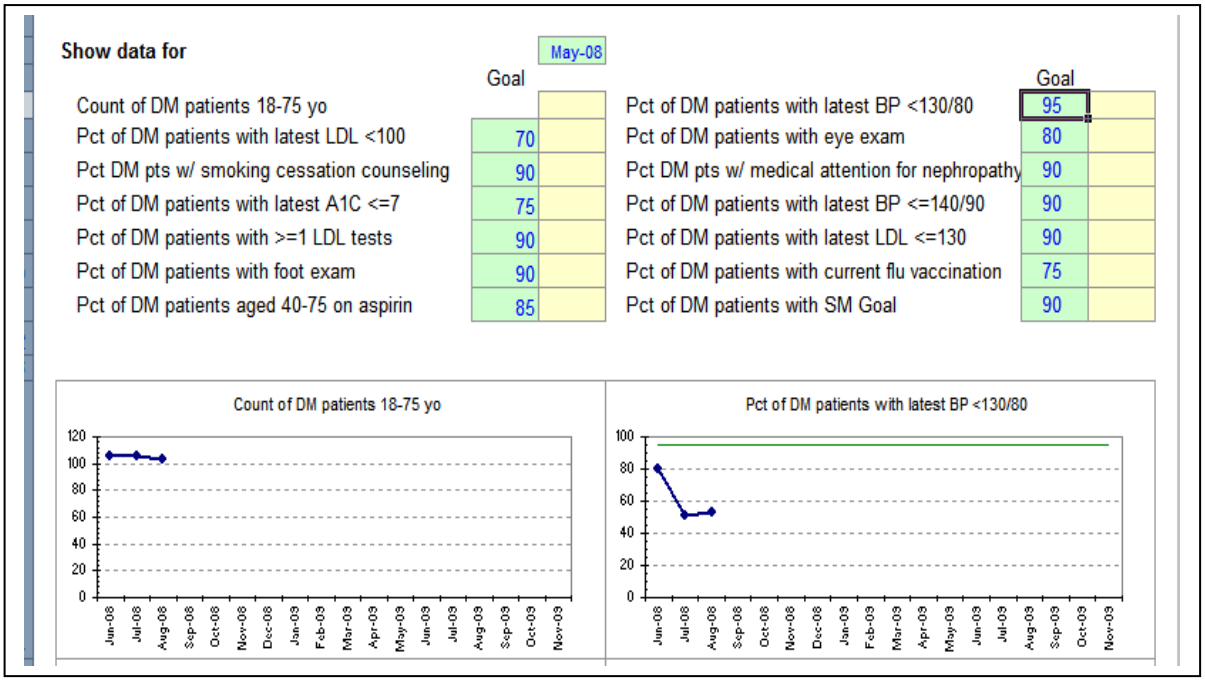
2 pts

SOME
Electronic Systems

The practice measures performance and produces reports using nationally approved clinical measures.

This element requires the practice to show the ability to report measures endorsed by the National Quality Forum (NQF) for use at the physician or practice level. Scoring is based on number of measures reported. Access NQF-endorsed measures at: http://www.qualityforum.org/pdf/Btblendorsedmeasurescurrent.xls.

EXAMPLE* Documentation



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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 8F: Electronic reporting—external entities

1 pt

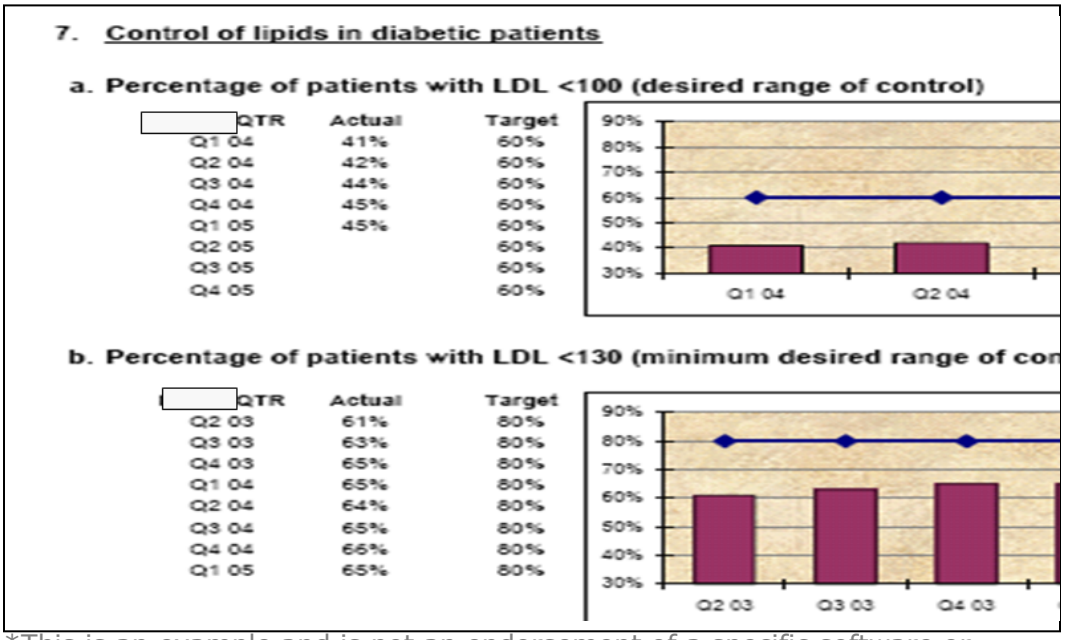
FULLY INTEGRATED
Electronic Systems

The practice electronically transmits performance measures to external entities.

This element assesses the practice's ability to transmit performance reports (Element 8E) electronically to health plans, to the public sector and to other entities external to the practice. The practice may receive partial credit for this element if its electronic system can transmit reports to external entities but the practice has not transmitted reports.

TIP: To demonstrate compliance with this element, the practice describes the reports it transmits, the external entity that receives the report and a screen shot of the portal or other system showing transmission.

EXAMPLE* Documentation



7. Control of lipids in diabetic patients

a. Percentage of patients with LDL <100 (desired range of control)

QTR	Actual	Target
Q1 04	41%	60%
Q2 04	42%	60%
Q3 04	44%	60%
Q4 04	45%	60%
Q1 05	45%	60%
Q2 05		60%
Q3 05		60%
Q4 05		60%

b. Percentage of patients with LDL <130 (minimum desired range of con

QTR	Actual	Target
Q2 03	61%	80%
Q3 03	63%	80%
Q4 03	65%	80%
Q1 04	65%	80%
Q2 04	64%	80%
Q3 04	65%	80%
Q4 04	66%	80%
Q1 05	65%	80%

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 9A: Availability of interactive Web site

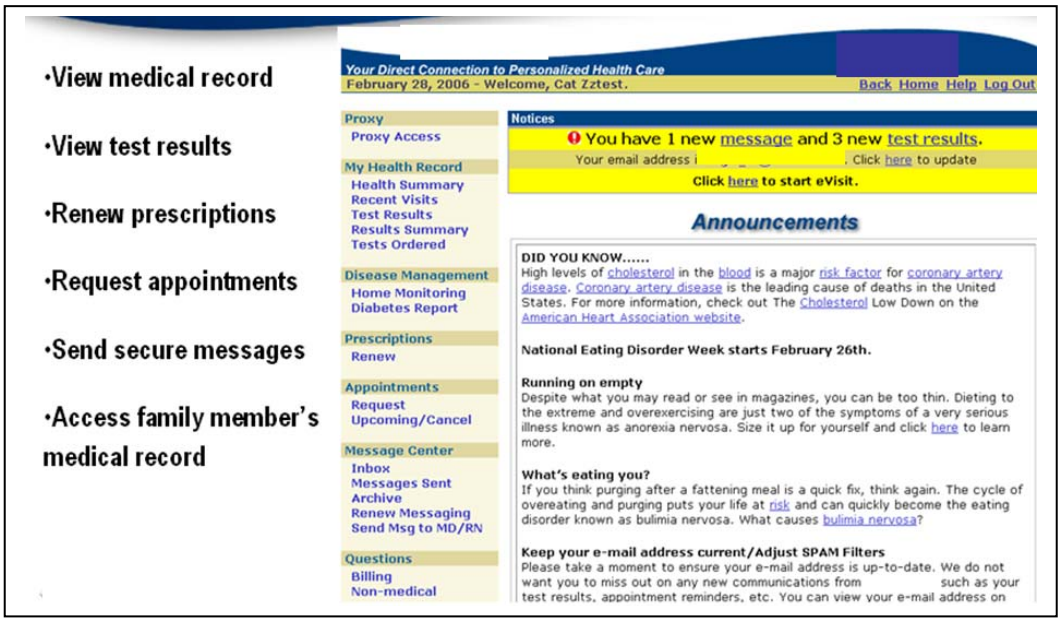
1 pt

SOME
Electronic Systems

The practice maximizes electronic communication with patients via the Web to support patient access and self-management.

A practice that maintains a Web site is considered "advanced"; it meets the requirements of this element when it includes interactive functions such as patients' ability to request appointments, prescription refills, referrals and test results, and see sections of their medical record. A Web site may include the ability to enter data into a personal health record. Partial credit is given if the site includes any of these functions.

EXAMPLE* Documentation



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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 9B: Electronic patient identification

2 pts

SOME
Electronic Systems

The practice maximizes use of electronic communication capability with e-mails that notify patients about specific needs and clinical alerts.

A practice must demonstrate that it can communicate with its patients through e-mails to inform them about the need for care that requires clinical review or action; preventive care; specific tests; follow-up visits; or additional information on a particular medication or disease/case management support. NCQA expects practices to identify their patients who would benefit from such e-mail messages. The practice earns partial credit if it identifies patients who need e-mail communication but does not communicate with patients through e-mails.

EXAMPLE* Documentation

2006	DM Bronze Report (Monthly Refresh)							
MRN	Sex	BirthDate	Gly6Months	LDL12Months	AstAlt12Months	BP12Months	Weight12Months	FootExam12Months
	M		No	Yes	Not On Med	Yes	No	Yes
	M		Yes	Yes	Yes	Yes	Yes	Yes
	M		Yes	Yes	Not On Med	Yes	Yes	Yes
	M		Yes	Yes	No	Yes	Yes	No
	M		No	No	No	No	No	No
	M		No	Yes	Yes	Yes	Yes	No
	M		Yes	Yes	Not On Med	Yes	Yes	Yes
	M		Yes	Yes	Yes	Yes	Yes	No
	M		Yes	Yes	Yes	Yes	Yes	Yes
	M		Yes	Yes	Not On Med	Yes	Yes	No
	M		Yes	Yes	Yes	Yes	Yes	Yes
	M		Yes	Yes	Not On Med	Yes	Yes	Yes
	M		Yes	Yes	Not On Med	Yes	Yes	Yes

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Physician Practice Connections—Patient Centered Medical Home

ELEMENT 9C: Electronic care management support

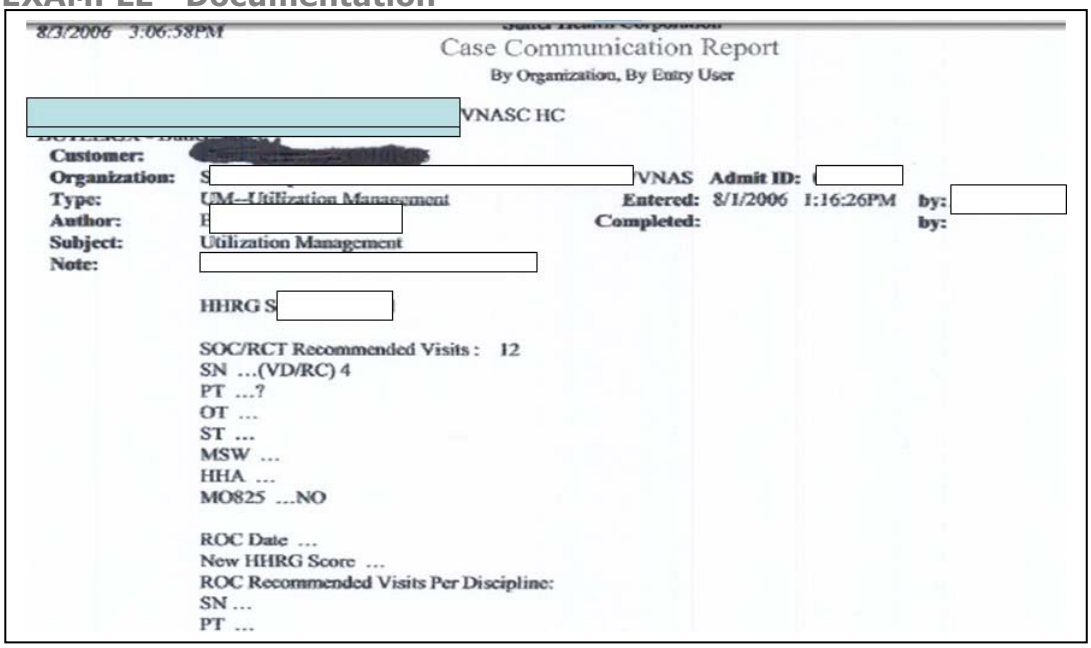
1 pt

SOME
Electronic Systems

The practice maximizes use of electronic communication among the care management team to support the care management process for patients with one of the three identified clinically important conditions.

This element awards credit to practices that use electronic communication to manage patients (e.g., exchanges between case management staff about patients, Web-based educational models for patient self-management).

EXAMPLE* Documentation



8/3/2006 3:06:58PM

Case Communication Report

By Organization, By Entry User

[redacted] VNASC HC

Customer:

Organization: [redacted] VNAS Admit ID: [redacted]

Type: UM--Utilization Management Entered: 8/1/2006 1:16:26PM by: [redacted]

Author: [redacted] Completed: by:

Subject: Utilization Management

Note: [redacted]

HHRG S [redacted]

SOC/RCT Recommended Visits : 12
SN ...(VD/RC) 4
PT ...?
OT ...
ST ...
MSW ...
HHA ...
MO825 ...NO

ROC Date ...
New HHRG Score ...
ROC Recommended Visits Per Discipline:
SN ...
PT ...

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