Program Operations 1: ACO Structure

The organization clearly defines its organizational structure.

Intent

The organization has the infrastructure to coordinate providers and works to increase quality, improve patient experience and effectively manage its financial resources.

Element A : Program Structure

The organization's program description includes the following:

1. **ACO program structure**
2. **The governing body of the ACO**
3. **The specific role, structure and functions of the governing body, including meeting frequency**
4. **Designated physician or clinician leadership with substantial involvement in the ACO**
5. **Defined goals addressing clinical quality, patient experience, and cost.**
6. **Process to annually review the overall performance of the organization with its governing body**
7. **Process to conduct an organizational assessment and review the results with the governing body.**

Scoring

100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Explanation

Organization description

The ACO describes the framework within which the business operates. Defining the program structure facilitate goals achievement and helps organization leaders make decisions about resource use.

The program description must be organized and written so that staff members and affiliated providers can understand the organization's goals, objectives and structure.

Structure

The organization defines the decision-making structure, operational framework and tasks to support its goals and objectives. Furthermore, the organization defines how it uses its resources to achieve its goals and should include the following information.

- How the program is organized to meet program objectives
- Functional areas and their responsibilities
- Reporting relationships

Accountability to the governing body

The **governing body** is the organization's board of directors, which is responsible for organizational governance. The governing body provides leadership, establishes accountability and provides the structure to align the functions of an ACO. The organization must identify its board members, define their roles, describe the

responsibilities of the board (e.g. identify decisions which are reserved for the board), including their meeting frequency.

Designated physician or clinician leader

The program description specifies the role of the designated physician or clinician leader in the governance of the organization. The designated physician or clinician leader must participate on or advise the board or have a substantial management function. Substantial management functions include roles such as chief executive officer, chief medical officer, chief nursing officer, medical director, etc.

Performance goals

A **performance goal** is the desired level of achievement that the organization sets for itself. The organization must define goals for clinical quality, patient experience and cost.

Cost goals may include those addressing:

- Resource stewardship.
- Efficiency
- Per capita cost reduction
- Resource use

Annual evaluation

NCQA reviews the organizations documented process for annually reviewing its performance with the governing body. The documented process must include a description of the information to be reviewed. This information must include:

- A description of completed and ongoing activities for the previous year, including activities to improve clinical care, patient experience and resource use.
- Quantitative analysis and trending of performance measures including a comparison to goals
- Root cause analysis or barrier analysis to identify reasons when its goals are not met.

Organizational assessment

An organizational assessment is a survey of organization's culture which may help it to identify social and structural elements critical to achieving high performance. NCQA reviews the organizations process for conducting the assessment and reviewing it with the governing body. The process must include a description of the assessment tool, frequency staff is assessed, and a description of the staff included in the survey.

Examples None.

Element B: Stakeholder Participation

The organization involves the following stakeholder groups in the oversight of ACO functions:

1. **Primary care practitioners**
2. **Consumers (or community representatives)**
3. **Specialists**
4. **Hospitals, if applicable.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Explanation The organization must describe how it involves key stakeholder groups in the oversight of ACO functions. Involvement may be through:

- Board membership
- Participation on a subcommittee of the board
- As part of the organization's management staff. (This option is not applicable to consumer stakeholders)

If involvement is through participation on a board subcommittee, the organization must describe the role, function and reporting relationship of the subcommittee to the board.

Key stakeholders include:

- primary care practitioners and specialists who provide care for the organization's patients
- hospital(s) and other providers that are part of the legal structure of the ACO or who contract with the organization to provide care
- consumers or community representatives.

Examples None.

Element C: Working with Others

The organization describes how it will work with the following entities:

1. **Providers**
2. **Community resources**
3. **Consumers**
4. **Payers.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Explanation NCQA reviews the organization's description of how it works with the following entities to achieve its objectives:

- Providers
- Community resources
- Consumers
- Payers.

A **provider** is an institution or organization that provides services for the organization's members, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Community resources include clinical or non-clinical caregivers who work within a geographic area that provide public health and community-based resources that are essential to maintaining the health of a population.

Consumers are individuals in the organization's service area that receive care from the organization or its affiliated providers.

A **payer** is an entity that is responsible for reimbursing for health care services such as health plan or CMS.

Examples None.

PO 2: Resource Stewardship

The organization has the capability to manage its resources effectively.

Intent

The organization has the staffing and infrastructure to effectively manage its resources.

Element A: Clinical Utilization Management

The organization has a clinical utilization management plan which includes:

1. **Process for verifying patient eligibility and benefits**
2. **Information systems to track utilization**
3. **Risk adjustment methodology used to determine required reimbursement-levels**
4. **How it works with payers to determine reimbursement requirements**
5. **Process to conduct ongoing monitoring of services rendered and the cost for those services, compared to the revenue received**
6. **Stop-loss or reinsurance provisions.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process, Materials

Scope of review

Look-back period

Explanation Organizations must appropriately allocate resources to ensure patients receive needed care. A management plan can help organizations determine manage its financial resources efficiently.

Examples None.

Element B: Resource Stewardship

The organization has a plan to manage its use of resources which includes:

1. **Description of staff performing UM functions**
2. **Written UM decision-making criteria that are objective and based on medical evidence**
3. **Written policies for applying the criteria based on individual needs**
4. **Written policies for applying the criteria based on an assessment of the local delivery system**
5. **Involvement of appropriate practitioners in developing, adopting and reviewing criteria**
6. **Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.**

Scoring	100%	80%	50%	20%	0%

Data source

Documented process

Scope of review

Explanation

Staff Performing UM functions

NCQA reviews a description of the staff responsible for specific UM activities, including those with the authority to deny coverage. NCQA also reviews the extent of involvement of a physician and a behavioral healthcare practitioner, if the organization covers behavioral healthcare services.

Written UM decision-making criteria

NCQA reviews the organization's documented process for evidence of the UM decision-making criteria and its process for applying the criteria to individual members, and reviews reports for evidence of annual review of the UM criteria.

The organization and its delegates must have clearly written criteria to evaluate the necessity of medical and behavioral healthcare services. There must be written criteria for all UM activities that the organization conducts, including review of referrals that are subject to organization or delegate approval. NCQA reviews UM criteria only for the UM functions that the organization performs.

Criteria may be widely applicable principles or more diagnosis- or procedure-specific, detailed protocols. If the organization delegates UM, it is not necessary for all delegated entities to perform the same UM functions or to use the same UM criteria as the organization, but each organization must use criteria based on medical evidence.

Applying criteria

Nationally developed procedures for applying criteria, particularly those for length of hospital stay, are often designed for "uncomplicated" patients and for a comprehensive delivery system; they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to inpatient care. Therefore, the organization must consider at least the following when applying criteria to a given individual.

- Age
- Comorbidities
- Complications
- Progress of treatment

- Psychosocial situation
- Home environment, when applicable

The organization also considers characteristics of the local delivery system available to specific patients.

- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Coverage of benefits for skilled nursing facilities, subacute care facilities or home care where needed
- Local hospitals' ability to provide all recommended services within the estimated length of stay

The organization may address the aspects listed above as part of the UM criteria or in separate, overriding instructions to staff in the following forms:

- One or more sets of standing written instructions for staff to follow in every case to determine whether UM guidelines are appropriate for each member
- Specific instructions tailored for each procedure or diagnosis, or for groups of procedures or diagnoses, that lead to a decision appropriate for the member.

Instructions for either form may be in the case management procedures, general UM procedures or online instructions.

Written UM procedures must direct decision makers to alternatives when the above factors indicate that UM guidelines are not appropriate. Possible alternatives in these instances include a secondary set of UM criteria and individual case discussions.

NCQA reviews the organization's written procedures to determine whether they contain instructions for applying the criteria.

Practitioner involvement

The organization documents that practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria. The organization may solicit opinions through practitioner participation on a committee or by considering comments from practitioners to whom it has circulated the criteria.

In large regional or national organizations, a central office may develop or adopt criteria, as long as it involves appropriate practitioners in the process. NCQA recognizes that "appropriate" can encompass a broad range of practitioners and does not limit the definition to actively practicing practitioners.

Reviewing and updating criteria

The organization may have criteria for stable processes or procedures where new scientific evidence is not available. For this type of criteria, a designated group may perform the review to determine if any further review (e.g., a formal literature review) is necessary. In other instances, the process may only entail a formal literature review.

Exceptions

This element is NA if the organization and its delegates do not make UM decisions and all services are automatically approved.

Factor 6 is NA for UM criteria in use for less than 12 months.

Examples None.

PO 3: Health Services Contracting

The ACO arranges for pertinent health care services and determines payment arrangements and contracting.

Intent

The organization contracts with practitioners and providers to provide the full continuum care and foster open communication and cooperation with QI activities.

Element A: Arranging For Services

The organization arranges for the provision of the following health care services for its defined population:

1. **Primary care**
2. **Specialty care**
3. **Urgent and emergency care**
4. **Inpatient Care.**

Scoring	100%	80%	50%	20%	0%

Data source Materials

Scope of review

Explanation

Accountable care organizations are envisioned to be responsible for the full continuum of care for a defined population. Though significant impacts on costs and quality can be achieved through improvements in primary care; greater opportunities to reduce cost and improve quality can be gained through improved inpatient care and management of patients with complex conditions. These improvements require the involvement of and coordination with inpatient providers and specialists.

Organizations may include these entities in their legal structure or make provisions to have the services provided by these entities available to their defined population. Arrangements could be contractual, through collaborations, ownership arrangements or joint ventures.

NCQA reviews documentation to determine whether the organization has made arrangements to make these services available to its defined population.

NOTE FOR PUBLIC COMMENT: Clearly this is not a comprehensive list of the health services likely to be required. We are interested in suggestions on which service types to list or alternative approach to assuring the organization has made the necessary arrangements for the types of services most likely to be needed.

Examples

- Contract with an urgent care facility (free-standing, hospital-based, or group-affiliated).
- Multi-specialty provider group including primary care practitioners included in

the organization's legal structure or list of contracted providers.

Element B: Practitioner Payment Arrangements

The organization:

1. **Bases at least a portion of its practitioners' compensation on the performance of the ACO as a whole using clinical quality, cost and satisfaction indicators**
2. **Informs patients about performance-based payment arrangements with practitioners**.
3. **Has a process to monitor utilization patterns for inappropriate restrictions on care that may arise unintentionally from existing payment arrangements.**

Scoring	100%	80%	50%	20%	0%

Data source

Documented process

Scope of review

Explanation

A **practitioner** is a licensed or certified professional who provides medical care and behavioral healthcare.

To align incentives between the organization and its practitioners, the ACO should have a payment mechanism that rewards practitioners based on the performance of the overall organization.

NCQA reviews the organization's documented process for how it compensates practitioners. The process must include whether it uses quality, cost and satisfaction indicators in its compensation structure and how much of the practitioners' total compensation is performance-based.

The organization informs patients about performance-based payment incentives offered to practitioners. Transparency in practitioner payment arrangements can reassure consumers that the organization is not incentivizing practitioners to withhold needed care. NCQA reviews the organization documented process for informing patients about performance-based practitioner payment arrangements. The documented process must include how the organization makes this information available to patients and frequency of notification.

NOTE FOR PUBLIC COMMENT: We recognize that there are other mechanisms that organizations may use and are interested in suggestions about other ways that organizations might align incentives across the providers.

Examples

None.

Element C: Payer Contracts

Contracts with payers specifically address:

1. **Payment method used to reimburse for care**
2. **Payment turnaround times**
3. **Population covered**
4. **Service categories included**
5. **Services covered as well as scope and duration of treatment covered**
6. **Attribution model used to assign patients.**

Scoring

100%	80%	50%	20%	0%

Data source

Scope of review

Explanation

Contracts between the payers and the organization may vary according to the needs of the parties. The contracts should address the following.

- **Payment method**. The organization identifies the method payers use to reimburse for care. If the organization uses different payment methods to reimburse for different types of care it documents this in the contract.
- **Payment timelines.** The contract specifies payment-turnaround times.
- **Population covered.** The services required by patients will be influenced demographic factors such as age, gender and socioeconomic status. Defining the population to be served by the organization will allow it to plan for needed care and determine adequate reimbursement levels. The organization must specify the populations covered under the contract. The defined population may include a product line (e.g. commercial, Medicare, Medicaid) or include a subset of enrollees as described by the payer.
- **Service categories**. Clearly defining the responsibilities of the organization allows it to proactively plan for patient care needs. Contracts must include the types of care covered (e.g. inpatient, outpatient, etc.).
- **Services covered, scope and duration**. The contract includes a description of the services included, scope of the services, and when coverage begins and ends (if applicable).
- **Attribution model.** The contract includes a description of the methodology used to assign patients to the ACO.

NCQA reviews up to three contracts with payers executed within the look-back period to determine whether they contain the required content.

NOTE FOR PUBLIC COMMENT: Our intent is to identify key features of the payer relationship that will support the ACO in effectively managing resources. Need to know who and what they are responsible for in order to effectively provide it. Features of payment arrangement help with cash flow management.

Exception

This element is NA for organizations participating exclusively in the CMS shared-savings program.

Examples

- Payment methods may include fee-for-service, capitation, shared savings arrangements, etc. The contract may specify that global capitation is used for maternity care and that fee-for-service payments with shared savings provisions are used for other types of care.

- The contract or addendum to the contract specifies that the following services for breast cancer treatment are covered under the contract:
    - Diagnostic mammogram examinations
    - Routine mammogram examinations after the maximum benefits under the routine physical exam provision have been paid
    - Mastectomy and lymph node dissection; complications from mastectomy including lymphedema
    - Reconstructive surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy
    - Breast prostheses following mastectomy.

AA 1: Availability of Practitioners

The organization ensures that it has sufficient numbers and types of practitioners who provide primary and specialty care.

Intent

The organization maintains an adequate network of primary care and specialty care practitioners (SCP) and maintains appropriate access to services.

Element A: Assessing Network Needs

The organization has a process to assess its defined population to determine:

1. **The number of primary care providers needed**
2. **The number and types of specialty care providers needed**
3. **Other (high volume) services/providers needed.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Look-back period

Explanation

NCQA reviews the organization's process for assessing it's patient population to determine the number and types practitioners needed to provide

- Primary care
- Specialty care
- Other types of services needed by its patients.

Primary care practitioners include:

- General practitioners
- Internists
- Family practitioners
- Pediatricians

Specialty care practitioners include:

- OB/GYN
- Cardiologists
- Dermatologists
- Ophthalmologists
- Orthopedic surgeons
- Gastroenterologists.

.

Examples None.

Element B: Availability of Practitioners

To ensure the availability of practitioners who provide primary care and SCPs, the organization:

1. **Establishes quantifiable and measureable standards for the number of practitioners providing primary care**
2. **Defines which practitioners serve as high-volume SCPs**
3. **Establishes quantifiable and measureable standards for the number of high-volume SCPs**
4. **Annually analyzes performance against the standards.**

Scoring	100%	80%	50%	20%	0%

Data source Documented Process, Reports

Scope of review

Explanation

Availability is the extent to which the organization provides the appropriate types and number of practitioners and providers necessary to meet the needs of its patients within defined geographical areas.

Documentation
NCQA reviews the organization's documented process for factors 1 and 2 and reviews reports for factors 3 and 4.

Identifying primary care practitioners
The organization must determine practitioner availability for the following types of primary care practitioners.

- General practitioners
- Internists
- Family practitioners
- Pediatricians.

Organizations may include nurse practitioners in the practitioner availability standards if they are within the scope of credentialing and provide primary care as licensed independent practitioners.

Identifying high-volume specialists

- Identify practitioners located in an expected high-volume geographic area or in high-volume disciplines, or both
- Use available prior encounter data
- Identify certain types of practitioners most likely to provide services to the largest segment of the patients; for example, orthopedic surgeons might see more patients for treatment than neurosurgeons.

The organization includes the following as high-volume specialist in its access and availability policy.

- OB/GYN
- Cardiologists
- Dermatologists
- Ophthalmologists
- Orthopedic surgeons
- Gastroenterologists.

Availability standards
The organization must have quantifiable, measurable standards for:

- The number of practitioners providing primary care services
- Practitioner distribution in a given geographic region.

Standards must be realistic for the community, the delivery system and clinical safety.

Performance assessment
There must be evidence that the organization formally assesses its performance against the standards at least annually. The assessment methodology selected must allow direct measurement of performance against standards.

Self-reported data
The organization may use member self-reported data, such as satisfaction with practitioner availability.

Data analysis

NCQA reviews the rigor of the methodology, including the data source, the sampling (if used) and the analysis. Analysis of findings must include comparison of results against the standard and an analysis of the causes of any deficiencies (if appropriate) that must go beyond data display or simple reporting of results.

Examples

Expressing the number and geographic distribution of practitioners

- The percentage of patients with a practitioner of each type available within a certain number of miles
- The number of sites accepting new patients for primary care in each geographic area
- The ratio of member-to-practitioner availability in each area and a determination of acceptable driving times to primary care sites
- The percentage of open practices within each geographic area.

Measurements against the standard

If the standard is “acceptable driving time to a practitioner who provides primary care services,” the measurement must calculate driving times from locations where patients reside to locations of available practitioners.

Element C: Assessment of Access

The organization collects and performs an annual analysis of data to evaluate access to care:

1. **During office hours**
2. **Outside typical office hours.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process, Materials, Reports

Scope of review

Explanation

Access to care during office hours indicates the clinician and care team are accessible to patients via:

- Office visit
- Secure electronic messaging and telephone for routine and urgent care needs
- The practice sets aside time for same day appointments (open access, advanced access or same-day scheduling).

Access to care outside typical office hours indicates the clinician and care team are accessible to patients via:

- Appointments for routine and urgent care after hours based on patient need or triage
- Processes to return calls or respond to electronic messages in a timely manner. Timeframes are determined by the practice to meet the clinical needs of the patient population- not by the ACO organization.

The organization performs an analysis to determine whether it provides sufficient access to its assigned patients. NCQA reviews the organization's documented process for conducting an access assessment and reports documenting the results of assessments performed in the review period. Reports must include a qualitative analysis of results and document opportunities to improve access, if any.

Examples

- Surveys to patients to determine satisfaction with access during and outside of typical office hours
- Systematic review of participating practice and provider hours to determine:
  - Availability of same day appointments
  - Availability of appointments for routine care
  - Availability of appointments for urgent care
  - Availability of medical record data for after hours care.

Element D: Ensuring Access

The organization takes action to improve access to care during office hours and after hours, if necessary.

Scoring	100%	80%	50%	20%	0%

Data source Materials, Reports

Scope of review

Explanation The organization ensures that it provide adequate routine, urgent, and after-hours care options. The organization takes action to improve access issues identified in Element C.

Examples

- Programs addressing specific population needs: home care visits, "one-stop shop" clinics for underserved populations at risk for specific diseases.
- Organize a pool of providers that rotate after hours coverage for providers in the network.
- Implement nurse advice lines to provide clinical advice during and after hours.
- Contracting with recognized PCMH's who have processes for providing routine and after hours care.

Element E: Practitioner Directory

The organization has a Web-based physician directory that includes the following physician information to help patients and prospective patients choose physicians.

1. **Name**
2. **Gender**
3. **Specialty**
4. **Office locations**
5. **Languages spoken by the physician or clinical staff**
6. **Board certification**
7. **Accepting new patients.**

Scoring	100%	80%	50%	20%	0%

Data source

Scope of review

Explanation

NCQA based its required data elements for Web-based directories on the recommendations of an expert panel summarized in the Commonwealth Fund Report, *Recommendation for Improving the Quality of Physician Directory Information on the Internet* and the follow-up research on those recommendations by the Midwest Business Group on Health.

The organization includes the following data in its directory.

- *Name,* including both first and last name of the physician.
- *Gender*.
- *Board certification,* including a list of board certifications as reported by the ABMS and either:
  - A link directly to ABMS to verify current status, ***or***
  - Instructions on how to check the most current board certification status by going to the ABMS Web site. Links to DO board certification do not meet the intent of factor 6.
- *Acceptance of new patients* applies to general and internal medicine, family practice, pediatrics, obstetrics/gynecology and high-volume behavioral healthcare.
- *Languages spoken* by the physician or clinical staff (the organization may include office staff but must identify them as such). The organization is not required to include English in the list of spoken languages.
- *Office location,* including physical address and phone number of office locations.

The organization may share data with prospective patients upon request and in a restricted manner (e.g., time-limited access to a Web report). Prospective patients are individuals who have the option to choose the organization to provide health care.

Data fields cannot be collapsed or left blank. The organization must enter information regarding the data. For example, if the physician is not board certified, the entry should state "none" or "not board certified." For physicians with multiple board certifications, the organization should include the validated certifications in which the physician is currently practicing or that the physician wants listed.

NOTE FOR PUBLIC COMMENT: Our intent is to assure that patients aligned with the ACO are clear about who is in and who is out of the ACO 'network'. We welcome other approaches to allowing this protection.

Examples None.

Element F: Provider Directory

The organization has a Web-based hospital directory that includes the following information on providers that it works with.

1. **Facility name**
2. **Location**
3. **Accreditation.**

Scoring

100%	80%	50%	20%	0%

Data source

Scope of review

Explanation

A **provider** is an institution or organization that provides services for patients. Examples of providers include hospitals and home health agencies. NCQA uses the term practitioner to refer to the professionals who provide health care services, but recognizes that a "provider directory" generally includes both providers and practitioners and the inclusive definition is the more common use of the word. This element evaluates information in directories related to institutions.

The organization includes the following data in its directory.

- *Facility name,* including the full name of the hospital
- *Location,* including the physical address and phone number of primary and affiliated locations
- *Accreditation,* including accreditation status held from applicable accreditation bodies (e.g., The Joint Commission, Commission on Accreditation of Rehabilitation Facilities [CARF], AOA).

Prospective patients are individuals those who have the option to choose the organization to provide health care. The organization may share data with prospective patients upon request and in a restricted manner (e.g., time-limited access to a Web report).

Rental network hospitals are not required to be included in the directory if the organization contracts with the rental network and not with the hospitals within the network. The organization must demonstrate that it meets this element for all hospitals with whom the organization holds a direct contract.

Data fields may not be collapsed or left blank. The organization must enter information regarding the data (e.g., the specific accreditation status should be entered [Accredited, Provisional, Denied, Not Accredited]).

A link to the appropriate accreditation organization meets factor 3 if the site provides the accreditation status. A link to an accrediting organization's general Web site does not meet factor 3.

Examples

None.

Element G: Cultural Needs and Preferences

The organization:

1. **Assesses the cultural, ethnic, racial and linguistic needs of its patients**
2. **Adjusts the practitioners within its network to meet the preferences of its defined patients, if necessary.**

Scoring	**100%**	**80%**	**50%**	**20%**	**0%**
Data source	Reports				
Scope of review					
Look-back period					
Explanation	An organization that creates and maintains a practitioner network must facilitate linking patients with practitioners who can meet patients' cultural, racial, ethnic and linguistic needs and preferences. The organization must use patients' expressed preferences to assess the availability of and facilitate linking patients to specified practitioner types.				
Examples	None.				

Primary Care 1: Practice Capabilities

The practice provides patients/families with access patient-centered primary care.

Intent

The practice provides patients/families with access to appropriate routine and urgent care.

Element A: Access During Office Hours

Practice has a written process, defined standards and demonstrates that it monitors performance against the standards for:

1. **Providing same day appointments**
2. **Providing timely clinical advice by phone during office hours**
3. **Providing timely clinical advice by secure electronic messages during office hours.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process, Reports,

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

The clinician and care team are accessible to patients by office visit, secure electronic messaging and telephone for routine and urgent care needs. The practice staff determines the relative urgency of patient requests for same day access based on patient care needs and preferences.

Same day appointments

The practice sets aside time for same day appointments (open access, advanced access or same-day scheduling) for routine and urgent care based on patient need or triage.

NCQA reviews the process for scheduling same day appointments and reviews reports which document that the practice had same day appointments available for at least 5 consecutive days in the past 3 months. A report providing the average third available appointment may also be used.

Third available appointment rates measure the length of time between when a patient contacts the practice to request an appointment and the third next available appointment on the schedule for their clinician. The practice may measure availability for new patient physicals, routine exams and return visit exams, with the goal being zero days.

Clinical advice

Clinicians return calls or respond to electronic messages in a timely manner. The timeframe is defined by the practice to meet the clinical needs of the patient population. NCQA reviews the practice's process for providing timely clinical advice and reviews reports documenting response times for a minimum of 30 consecutive requests for clinical advice received via telephone call and 30 consecutive requests received

through electronic messages.

Examples None.

Element B: Access After Hours

Practice has a written process, defined standards and demonstrates that it monitors performance against the standards for:

1. **Providing access to routine and urgent care appointments outside regular business hours**
2. **Providing continuity of medical record information for care and advice when office is not open**
3. **Providing timely clinical advice by telephone when the office is not open.**

Scoring	100%	80%	50%	20%	0%

Data source

Documented process, Reports

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

Routine and urgent care

Practices offer access to routine and non-routine care beyond regular business hours such as early mornings, evenings or weekends. The appointment times beyond regular business hours should be determined by the needs of the patient population. A process is not required if the practice has regular extended hours. If the practice does not provide care beyond regular office hours, e.g., if the practice is small with limited staffing, it may make arrangements for patients to receive care with other (non-emergency room) facilities or clinicians. Those arrangements should include a method for providing and retrieving patient information before and after the visit which may occur through contact with the primary care clinician.

NCQA reviews the practices documented process for afterhours access. A process is not required if the practice has regular extended hours. NCQA also reviews a report documenting after hours availability or materials communicating practice hours.

Clinical information

Patient clinical information is made available to on-call staff and external facilities for after hours care. This may be provided by patients with individualized care plans or portable personal health records or may be accomplished through access to an electronic health record. If care is provided by a facility to which the practice is not affiliated or connected or a facility without access to the patient record, the practice makes provisions for patients to have an electronic or printed copy of a clinical summary of their medical record. Telephone consultation with the primary clinician or a clinician with access to the patient's medical record is also acceptable.

NCQA reviews the practices documented process for making medical record information available for after hours care.

Clinical advice after hours

Patients receive interactive clinical advice when the office is closed by telephone or secure electronic communication (e.g., electronic message, Website, etc). The

timeframe is defined by the practice to meet the clinical needs of the patient population.

NCQA reviews the documented process for providing timely clinical advice outside of regular office hours AND report summarizing actual response times for the practice. The report may be system generated or may be based on a spot check of at least 1 week of calls.

Examples None.

Element C: Practice Team

Practice manages patient care in the following ways:

1. **Defines roles for clinical and non-clinical team members**
2. **Has regular team meetings and communication process**
3. **Uses standing orders for services**
4. **Assigns and trains care team to coordinate care for individual patients.**

Scoring	100%	80%	50%	20%	0%

Data source

Documented process, Materials

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

Managing patients through team based care is a central tenet of the patient-centered medical home. Team-based care involves both clinical and non-clinical staff (e.g. clinicians, nurses, medical assistants) who work together and interact with patients and their caregivers to address the needs of the patient.

Roles

The organization defines the roles of clinical and non-clinical staff in job descriptions and emphasizes team-based care in evaluations. NCQA reviews the practice's job descriptions describing the roles and functions of team members.

Meetings and communication

Team meetings may include daily huddles or review of daily schedule with follow-up tasks. A daily "huddle" is a team meeting to ensure efficient patient visits by discussing patients on the day's schedule. A communication process may include email exchanges or messages in the medical record about the patient. NCQA reviews the practice's communication process and an example of a meeting summary, agenda or memo to staff.

Standing orders

Standing orders may be clinician pre-approved or executed as permitted by state law without prior approval of the clinician. Examples include standing test protocols, standing prescription orders, medication refills, vaccinations and routine preventive services. NCQA reviews the practice's standing orders.

Care coordination

Care coordination may include obtaining test and referral results and communicating with community organizations, facilities and specialists. NCQA reviews a description of training related to coordinating care and a schedule of trainings held.

Examples None.

Element D: Guidelines for Important Conditions

The practice implements evidence-based guidelines through point of care reminders for patients with:

1. ***First important condition**
2. **Second important condition**
3. **Third important condition must be related to unhealthy behaviors, mental health, or substance abuse**

***Core Meaningful Use requirement**

Scoring	100%	80%	50%	20%	0%

Data source

Documented process, Materials, Report, Record or files

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

The practice implements evidence-based guidelines to ensure that patients receive care consistent with the best evidence. This element requires clinicians to systematically identify patients for whom they will proactively plan and manage care.

Patients with conditions may be identified through a registry such as diabetes, asthma, hypertension or ADHD or a billing system or EHR. The practice must demonstrate the following for each condition:

- Evidence-based guidelines used to manage the patient's care
- Implementation of the guidelines in managing the patients care.

Note: The conditions identified in Factors 1, 2, 3 will also be used for the medical record review required for elements E, F and G.

Condition selection

Factors 1 and 2: When selecting patients for factors 1 and 2, practices should consider the following:

- Ability to treat the conditions or provide care management
- Availability of evidence-based clinical guidelines
- Participation in performance measurement initiatives associated with a specific condition, such as diabetes, hypertension, ADHD or asthma and/or for which the practice is receiving performance-based rewards
- Focus of practice quality improvement efforts.

Factor 3: This condition may be related to unhealthy behaviors or substance abuse, for example, obesity, smoking or other tobacco use, risky sexual behavior, overuse of illegal drugs, alcohol or prescription drugs. Mental health issues may include depression.

Factor 4: The practice identifies and provides whole-person care to patients with complex medical or high risk medical conditions. The practice has a process for identifying its complex or high risk patients through a billing, practice management, electronic medical record or health plan data.

Complex or high-risk patients may include two or more of the following issues:

- High resource utilization (e.g. visits, medication, treatment)
- Frequent emergency department use (2 or more in last 6 months)
- Frequent hospitalizations (2 or more in last year)
- Multiple co-morbidities, including mental health
- Non-compliance with prescribed treatments/medications
- Terminal illness
- Psychosocial status, social support or financial support that impedes ability for care
- Advanced age with frailty.

Pediatric practices

Relevant conditions may include, but are not limited to well-child care, asthma, obesity, ADHD, eczema, allergic rhinitis. Well-child care is an acceptable condition because there are established comprehensive guidelines for children that include regular office visits and regular developmental assessments and preventive care services. Well-child care should be specified by age group and may only be used as one important condition. For factor 4, relevant conditions may include children and youth with special health care needs such as and sickle cell disease.

NCQA reviews the following for this element:

- Process and criteria used to identify patients with each condition
- Reports with de-identified information documenting the number of patients identified with the four conditions.
- Evidence-based guidelines used for each condition
- Materials, such as chart tools and screen shots, demonstrating how the guidelines are implemented in patient care.

Examples None.

Element E: Managing Care

For the conditions identified in Element D, the care team manages all of the care needed by the patient:

1. **Conducts pre-visit planning for at least 75% of patients**
2. **Develops an individualized care plan in collaboration with patient/family that includes treatment goals that are reviewed and updated at each relevant visit for at least 75% of patients**
3. **Provides patient/family with plan of care for at least 50% of patients**
4. **Assesses and addresses barriers when patient has not met treatment goals for at least 50% of patients**
5. **Provides patient/family with clinical summary at each relevant office visit for at least 50% of patients**
6. **Identifies patients/families who might benefit from additional care management support for at least 50% of patients**
7. **Follows up with patients who have not kept important appointments for at least 50% of patients.**

Scoring

100%	80%	50%	20%	0%

Data source

Reports, Records or files

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

Pre-visit planning

The practice prepares for the patient visit prior to the appointment by having the patient complete any required paperwork and having lab tests, imaging tests or referral visits completed with results reviewed prior to the visit. An example of this is a letter or email notifying patient of needed pre-visit activities.

Individualized care plans address the care needs of individual patients, responsibilities of the medical home and specialists to whom the patient has been referred and the role of community services/support if appropriate. Care plans must include treatment goals and may be based on a template. The clinician reviews the care plan at each relevant visit to determine whether patients is improving or not compared to the treatment goal and whether changes in treatment plan are needed or whether patients needs assistance in adherence if the patient is adhering to the plan including taking prescription medications as prescribed and progress toward treatment goals.

Relevant visits are determined by the practice and the clinician but should relate to:

- Important or chronic conditions including well-child visits
- Visits that result in a change in treatment plan or goals
- Additional instructions or information for the patient/family
- Visits associated with transitions of care.

Pediatric practices using well-child as an important condition may use child development to assess progress. Treatment goals for pediatric patients may relate to weight gain, developmental achievement, immunizations for well-child care, obesity, asthma or ADHD management.

The practice provides patient/family with care plan tailored to their understanding and

use at home.

Barriers to goals
The clinician/team assesses or talks with the patient/family to determine reasons for limited progress toward treatment goals, and to help the patient/family address those barriers. Barriers to be addressed may include the patients' lack of understanding, motivation, financial need, insurance issues, adverse effects of medication or other treatment or transportation problems. The clinician also takes action (e.g. changes or adds treatment) if needed. A completed social history is acceptable.

Clinical summary
Provides a written clinical summary at relevant office visits. Relevant visits are determined by the practice and the clinician but should relate to:

- Important or chronic conditions
- Well-child visits
- Visits that result in a change in treatment plan or goals
- Additional instructions or information for the patient/family.

Referrals
When appropriate the practice refers patient to internal or external resources for care management support, for example to disease or case managers.

The practice follows up with patients who have not kept important appointments such as re-checks, preventive care, post-hospitalization.

The practice provides a report from electronic system or the Record Review Workbook. The practice determines the percentage of factors populated for each patient. The practice may use one of the following methods to calculate the percentage:

Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

> **Denominator** = Total number of patients seen at least once by the practice in the last three months with the three important conditions
> **Numerator** = Number of patients for whom each item is entered.

Method 2—Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important conditions.

> **Denominator** = The sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
>
> **Numerator** = The patients from the medical record review for whom all items are entered.

Note: A patient may have more than one important condition but each patient is counted only once.

Examples None.

Element F: Manage Medications

The practice manages medication in the following ways:

1. **Reviews and reconciles list of prescribed medications with patients/families at every care transition and at each relevant visit**
2. **Provides patients/families with information about new prescriptions**
3. **Assesses patient response to medications and barriers to lack of adherence.**

Scoring	100%	80%	50%	20%	0%

Data source

Reports, Records or files

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

It is important for the practice to review and document in the medical record all prescribed medications the patient is currently taking. In addition to medical home visits, the practice reviews and reconciles medications following visits to specialists, hospitalizations, emergency room visits. Medication review and reconciliation should occur at transitions of care, relevant visit and at least annually. Relevant visit is to be defined by the practice.

The practice has a process for providing patients/families with information about new medications including potential side effects, drug interactions, how to take the medication and consequences of not taking it.

The practice inquires about any problems taking the medication, side effects, difficulty taking it, whether they are taking the drugs as prescribed and if not, why not.

The practice provides a report from electronic system or the Record Review Workbook. The practice determines the percentage of factors populated for each patient. The practice may use one of the following methods to calculate the percentage:

Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

Denominator = Total number of patients seen at least once by the practice in the last three months with the three important conditions

Numerator = Number of patients for whom each item is entered.

Method 2—Review a sample of medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method

calls for choosing patients with the practice's most important conditions.

Denominator = The sample of patient medical records using NCQA's sampling method in the Record Review Worksheet

Numerator = The patients from the medical record review for whom **all items** are entered.

Note: A patient may have more than one important condition but each patient is counted only once.

Examples None.

Element G: Self-Care Process

Practice conducts activities to support at least 50% of patients/families in self-management:

1. **Documents patient/family self-management abilities**
2. **Develops and documents self-management and plan and goals in collaboration with patient/family**
3. **Provides or connects patients/families with educational and community resources to assist in self-management.**

Scoring	100%	80%	50%	20%	0%

Data source

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

The practice provides patients with self-management support and tools beyond counseling or guidance typically provided during an office visit. The practice provides or refers patients to self-management programs or classes. These programs can be offered through community agencies, a health plan or the patient's employer.

Self-management skills

Patients/families who feel they are able to manage their health condition, learn needed self-care skills, or adhere to treatment goals will have greater success managing their own care. Practices can use tools to assess readiness to change and self-management abilities, including questionnaires and self-assessment forms. The purpose of assessing self-management abilities is so that the practice can adjust the self management plan to the patient/family capabilities and resources.

Self-management plan

The practice works with the patient to develop a self-care plan that addresses the patient's health condition and includes goals and a way to track/monitor self-care. NCQA expects the practice to have documentation of providing written self-care plan to patients, families or caregivers.

Referrals to support programs

Educational programs and resources may include information about a medical condition and/or the patient's role in managing the condition. Resources include brochures, handout materials, videos, Web site links, pamphlets, etc. and resources (e.g. programs, support groups) within the community. Based on the practice's assessment of languages spoken by its patients (PCMH 2, Element A, Basic Data), materials in dominant languages (other than English) should be available for patients/families. Patients/families may be referred to resources outside the practice taking into account the resources that may or may not be covered by the patient/ family health insurance. Self-management programs, including weight loss and smoking cessation programs, asthma education, diabetes education and other health education classes or groups may be made.

Also referrals to community resources for the uninsured and underinsured or assistance in obtaining transportation to medical appointments may be made.

The practice provides a report from electronic system or the Record Review Workbook.

The practice determines the percentage of factors populated for each patient. The practice may use one of the following methods to calculate the percentage:

Method 1—Query the practice's electronic registry, practice management system or other electronic or manual systems. The practice may use this method if it can determine a denominator as described below.

Denominator = Total number of patients with one of the three important conditions seen at least once by the practice in the last three months

Numerator = Number of patients for whom at least four activities are entered.

Method 2—Review a sample of 36 medical records using the sample method in NCQA's Record Review Worksheet. Because it may be difficult to know the denominator, the practice may use the instructions in the Record Review Worksheet to choose a sample of 36 relevant patients and then check for the relevant items. Note that to allow for record review for multiple elements using the same sample, the method calls for choosing patients with the practice's most important

Denominator = The sample of 36 patient medical records using NCQA's sampling method in the Record Review Worksheet

Numerator = The patients from the medical record review for whom at least four activities are documented.

Examples None.

Element H: Test Tracking and Follow-Up

The practice has a documented process and demonstrates that it:

1. **Tracks all lab tests until results are available, flagging and following up on overdue results**
2. **Tracks all imaging tests until results are available, flagging and following up on overdue results**
3. **Flags abnormal lab results, bringing them to the attention of the clinician**
4. **Flags abnormal imaging results bringing them to the attention of the clinician**
5. **Notifies patients/families of normal and abnormal lab and imaging test results.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process, Reports, Materials

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

The practice routinely uses a manual or electronic system to order, track and follow-up on test results. Such systematic monitoring is important to ensure that needed tests are received and actions taken when the results indicate a need for action.

Tracking lab tests

All lab and imaging tests should be tracked from the time they are ordered until the results are available. The system should flag tests that have been ordered but the results have not been made available. "Flagging" refers to having a systematic method of drawing attention to results that have not yet been received by the practice. The flagging may be an automatic icon that appears in an electronic system or a manual tracking system with dates the results are expected. The expected time that results should be available varies depending on the test and is left to the discretion of the practice. The practice follows up with the lab or diagnostic center and if necessary, the patient, to determine why the test results are overdue.

Abnormal results

Lab and imaging tests with abnormal results should be flagged or highlighted and brought to the attention of the clinician to ensure timely follow-up with the patient/family.

Patient notification

Patients receive notification of normal lab results. Notification can occur via letter, online notice, telephone call, or during an office visit. The practice provides the patient with the abnormal results in a timely manner (defined by the practice) There must be evidence that the practice proactively notifies the patient of abnormal results; filing the report in the medical record for the next time the patient comes in does not meet the intent.

NCQA reviews the practice's documented process for lab and image tracking or and reviews reports or materials documenting that the process is followed. The practice

may submit a tracking log or screen shot if the process is automated.

Examples None.

Element I: Referral Tracking and Follow-Up

The practice coordinates referrals through the following:

1. ***Provides the consultant or specialist with the clinical reason for the referral and pertinent clinical information**
2. **Tracks the status of the referrals, including the timing for the referred service**
3. ***Follows up to obtain specialist's report.**

***Core Meaningful Use requirement**

Scoring	100%	80%	50%	20%	0%

Data source Reports, Materials

Scope of review NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation The referrals tracked by the practices with a log or electronic system are those **determined by the clinician** to be important to the treatment of the patient or as indicated by practice guidelines. It includes referrals to medical specialists, mental health and substance abuse specialists and other services.

Clinical reason for referral

The practice provides the following information when making a referral:

- Reason for and urgency of the referral
- Relevant clinical information, for example, patient's family and social history, clinical findings and current treatment
- General purpose of the referral (consultative, transfer of care or co-management) and needed follow-up communication/information.

Referral tracking

The practice has a tracking report which includes when the referral was made and the expected date to receive the report.

Referral follow-up

If the practice does not receive a report from the specialist, the practice is expected to contact the specialist's office regarding the status and expected date to receive the report, and document the effort to retrieve the report in the log or electronic system.

The practice provides reports or logs demonstrating that the data collected in the tracking system used by the practice. The logs may be may be a paper log or a report generated from the electronic system.

Examples None.

Element J: Quality Improvement Activity

The practice uses performance data to:

1. ***Set goals and take action to improve on at least 3 clinical quality measures**
2. **Set goals and take action to improve quality on at least 1 patient/family experience measure**
3. **Set goals and take action to address at least 1 identified disparity in care/service for vulnerable populations.**

***Core Meaningful Use requirement**

Scoring	**100%**	**80%**	**50%**	**20%**	**0%**

Data source

Reports

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

It is critical that the practice establish a clear quality improvement strategy and process which should include regular review of performance data, evaluation of performance against goals or benchmarks, identification and prioritization of opportunities for improvement, barrier analysis to understand reasons for performance not meeting goals, design and implementation of interventions to address the barriers and re-measurement to determine impact.

A goal is the desired level of achievement that the practice sets for itself as its standard of care.

The practice identifies areas of disparity in performance based on race, ethnicity or language and takes action to improve.

The practice provides r**eports** documenting its QI activities or completes the PPC-PCMH **Quality Measurement and Improvement** worksheet.

Examples

None.

Element K: Identify High Risk Patients

To identify high risk or complex patients the practice:

1. **Establishes criteria and a systematic process to identify high risk or complex patients**
2. **Determines percent of high risk patients.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process, Report

Scope of review

NOTE: ACOs with a high percentage of PCMH recognized practices may receive automatic credit for this element. The percent will be determined post-public comment. We invite comment on this proposed strategy.

Look-back period

Explanation

Criteria and process

The practice has specific criteria and a process based on these criteria to identify patients with complex or high risk medical conditions for **whole-person care planning and management**.

The criteria for identifying complex or high-risk patients is at the discretion of the practice and may include the following or a combination of the following:

- High resource utilization (e.g. visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care, e.g. 2 or more in last 6 months
- Frequent hospitalizations (2 or more in last year)
- Multiple co-morbidities, including mental health
- Non-compliance with prescribed treatments/medications
- Terminal illness
- Psychosocial status, social support or financial support that impedes ability for care
- Advanced age with frailty
- Multiple risk factors.

Identification of the patients may be through a billing or practice management system, electronic medical record, key staff or profiling performed by a health plan, if health plans providing profiles represent at least 75% of the patient population.

Note: A sample of the patients identified as high risk or complex will be included in the medical record review required for elements 3B, 3C and 4A.

Factor 2:

This factor calls for calculation of a percentage that requires a numerator and a denominator. The practice may use the following methodology to calculate the percentage.

Numerator = Patients identified as high risk or complex

Denominator = Total number of patients in the practice.

NCQA reviews the following for this element:

- Process and criteria used to identify patients.

- Number and percent of total population identified as high risk or complex.

CM 1: Data Collection and Integration

The organization collects and integrates data from various sources, including, but not limited to electronic sources for clinical and administrative purposes.

Intent

The use of multiple modalities for data collection and integration ensures that the organization collects data which meet the needs of clinical care and administrative purposes.

Element A: Process for Data Collection and Integration

The organization has a documented process for collecting and integrating data from the following sources:

1. **Outpatient claims or encounter data from participating practitioners and providers**
2. **Inpatient claims or encounter data from participating practitioners and providers**
3. **Outpatient claims or encounter data from non-participating practitioners and providers**
4. **Inpatient claims or encounter data from non-participating practitioners and providers**
5. **Electronic health records**
6. **Pharmacy data**
7. **Laboratory results**
8. **Health appraisal results.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Look-back period

Explanation

Data integration is using or combining data from multiple sources and databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy, patient self report), across sites of care (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational).

Creating links between systems helps coordinate patient care and deliver the right care to patients at the right time. Data integrated from these sources can be used to support a variety of functions including, but not limited to:

- Population of patient care registries
- Performance reporting
- Population health management (e.g. disease management, case management).

Having a process to collect and integrate information allows the organization to proactively identify data needs and uses.

NCQA reviews the organizations documented process to collect and integrate information from available data sources. The documented process must include:

- Data sources (i.e. claims, lab results)
- The integration method used. NCQA does not require the use of a particular integration model.
- Whether it collects data from care received outside of the organization or from non-contracted practitioners and providers (non-participating practitioners). If the organization receives this data, it must document how it integrates it with data from other sources. This process may be the same as that used to integrate data from its own practitioners and providers (participating practitioners).

All factors are considered applicable; the organization must have the capability to integrate the data even if it does not currently have access to some of the listed data sources.

Examples Process flow describing data sources and model for integrating the data.

Element B: Data Collection and Integration

The organization collects and integrates data from the following sources:

1. **Outpatient claims or encounter data from participating practitioners and providers**
2. **Inpatient claims or encounter data from participating practitioners and providers**
3. **Outpatient claims or encounter data from non-participating practitioners and providers**
4. **Inpatient claims or encounter data from non-participating practitioners and providers**
5. **Electronic health records**
6. **Pharmacy data**
7. **Laboratory results**
8. **Health appraisal results.**

Scoring	100%	80%	50%	20%	0%

Data source Materials, Reports

Scope of review

Look-back period

Explanation

The organization must submit examples of de-identified materials or reports that include evidence of the integrated data types. Organizations may submit multiple examples that collectively demonstrate all data types integrated by the organization or by submit one example that demonstrates integration of all data types.

All factors are considered applicable; the organization must have the capability to integrate the data even if it does not currently have access to some of the listed data sources.

Examples

- System demonstration
- Screen shots
- Performance reports
- Patient care registries.

Element C: Patient Information

The organization uses an electronic system that records the following as structured data:

1. ***Date of birth for >50% of patients**
2. ***Gender for >50% of patients**
3. ***Race for >50% of patients**
4. ***Ethnicity for >50% of patients**
5. ***Preferred language for >50% of patients**
6. **Telephone number(s) for >80% of patients**
7. **Email address for >80% of patients**
8. **Dates of previous clinical visits for >80% of patients**
9. **Legal guardian/health care proxy for >80% of patients**
10. **Primary caregiver for >80% of patients**
11. **Presence of advance directives for >80% of patients**
12. **Health insurance information for >80% of patients**

***Core Meaningful Use requirement**

Scoring	100%	80%	50%	20%	0%

Data source Report

Scope of review

Explanation The organization collects patient information through a practice management system or registry, an EHR or an integrated electronic system. The system used should be searchable for each factor and capable of creating reports.

NCQA reviews reports that document the percentage of the assigned patients seen in the previous 12 months who had structured data entered into the electronic system.

Examples

Element D: Clinical Data

The organization uses an electronic system to record and chart changes in the following searchable data:

1.	***Problem list with current and active diagnoses for >80% of patients**	☐	☐	
2.	***Allergies, including medication allergies and adverse reactions for >80% of patients**	☐	☐	
3.	***Blood pressure with date of update for >50% of patients**	☐	☐	
4.	***Height for >50% of patients**	☐	☐	
5.	***Weight for >50% of patients**	☐	☐	
6.	***BMI for >50% of adult patients**	☐	☐	☐
7.	***Length/height, weight, and head circumference (≤ 2 years of age); BMI percentile (2-20 years) with capability to plot changes over time for >50% of pediatric patients**	☐	☐	☐
8.	***Status of tobacco use for patients 13 years and older for >50% of patients**	☐	☐	☐
9.	***List of prescription medications with date of updates for >80% of patients.**	☐	☐	

***Core Meaningful Use requirement**

Scoring	100%	80%	50%	20%	0%

Data source Report

Scope of review

Explanation The organization collects clinical information on its patients through an EHR or integrated electronic system. The system used should be searchable for each factor listed above and be capable of generating reports.

NCQA reviews reports that document the percentage of the assigned patients seen in the previous 12 months who had clinical data entered into the electronic system.

Examples None.

Element E: Practice Access to Electronic Data

The data collected in the organization's electronic system can be retrieved and modified by practitioners at the practice site.

Scoring	100%	80%	50%	20%	0%

Data source

Reports

Scope of review

Explanation

Patient and clinical information collected through the organization's practice management system, EHR or integrated electronic system must be accessible to the organization's participating practitioners. The system used should be searchable for each factor and capable of creating reports. Practitioners must have the capability to modify the information in these systems.

NCQA reviews reports that document the percentage of participating practitioners that can retrieve and modify data in the organization's electronic system. If the organization maintains patient care registries separate from its EHR, it must document the percentage of participating practitioners with access each system. Registry access may be limited to practitioners based on clinical need. The score will be determined by an average of access to EHR data and separate registries if applicable.

Examples

None.

CM 2: Initial Health Assessment

The organization conducts an initial assessment of new patients' health within 90 days assignment to the ACO.

Intent

Assessment of patient health is relevant to the management of clinical needs.

Element A: Health Assessment

The organization has a process to administer a health appraisal (HA) to eligible individuals within 90 days of assignment.

Scoring	100%	80%	50%	20%	0%

Data source
Documented process, Materials

Scope of review

Look-back period

Explanation

The organization must have a process to assess a new patient's health status within 90 days of the patient's assignment to the organization. This initial assessment does not require the organization to conduct a physical exam, and it may take the form of a phone call, home visit or questionnaire.

The process must include how the organization follows up with patients who it could not reach or assess in its initial attempts.

Use of vendors for HA services
The organization may contract with a vendor to provide HA services.

NCQA reviews the documented process to administer health appraisals and the HA tool used.

Examples
None.

CM 3: Population Health Management

The organization uses appropriate data to identify population health needs and implements programs as necessary.

Intent

Accurate identification of care needs and the provision of population health management programs enables organizations to provide quality patient-centric care.

Element A: Identifying Care Needs

The organization has a documented process to identify patients who are eligible for:

1. **Wellness or preventive care services**
2. **Chronic disease management services**
3. **Complex case management.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Explanation

Population health management seeks to better manage the care and health of both chronically ill patients and those who are at risk but who have not experienced an acute event.

A **wellness and health promotion program** consists of a comprehensive plan that helps patients to change their lifestyles and move toward a state of optimal health. It includes health assessment (HAs), interventions and activities.

Disease management (DM) is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. DM programs may focus on a single index disease or condition (e.g., diabetes, asthma, high-risk pregnancy) or focus across conditions to manage patients with multiple diseases or risk factors.

Complex case management is the coordination of care and services provided to patients who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Eligible patients are patients diagnosed with or at risk for a condition or eligible for the population health program.

Documented process

The organization has a documented process to identify patients who qualify for population health management programs for:

- Wellness or preventive care services
- Chronic disease management services
- Complex case management.

The documented process must include:

- The data types used (e.g. claims, lab results, HA results) to identify eligible patients
- Criteria used to stratify or determine care needs
- Time frames used to identify patients from the time it receives new or updated information
- Description of the population health management programs or services patients are eligible for (e.g. tobacco cessation, diabetes disease management).

Organizations may utilize identification criteria developed in-house, by population-health or disease management vendors, or by health-plan clients.

Examples

The documented process for determining patient needs may include:

- Flowcharts of the stratification system
- Computer codes to stratify patients by diagnosis codes or claims or lab data
- Algorithms for stratifying patients by risk factors
- Written patient stratification or assessment criteria or procedures
- Predictive modeling algorithm.

Element B: Data Sources for Identification

The organization's documented process to identify patients who qualify for the programs in Element A include the following data types:

1. **Outpatient claims or encounter data from participating practitioners and providers**
2. **Inpatient claims or encounter data from participating practitioners and providers**
3. **Outpatient claims or encounter data from non-participating practitioners and providers**
4. **Inpatient claims or encounter data from non-participating practitioners and providers**
5. **Electronic health records**
6. **Pharmacy data**
7. **Laboratory results**
8. **Health appraisal results.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Explanation NCQA reviews the organization's documented process to identify patients for population health programs (Element A) for evidence of the data types used. As some data types are not applicable to every population health program (e.g., laboratory data may not be a data source used by the organization to identify individuals with asthma), the organization may provide documentation from multiple programs to demonstrate that all data types are used.

Examples None.

Element C: Providing Population Health Management

The organization systematically identifies eligible patients and provides the following population health management services:

1. **Wellness or preventive care programs**
2. **Chronic disease management programs**
3. **Complex case management.**

Scoring	100%	80%	50%	20%	0%

Data source

Reports

Scope of review

Explanation

NCQA reviews reports which detail the number of patients identified for each program type and describe the number and types of interventions patients received.

Programs may be in-house, provided by a population health or disease management vendor or health-plan based.

Examples

None.

CM 4: Practice Support

The organization provides resources for or supports the use of patient care registries, electronic prescribing and patient self-management.

Intent

The organization encourages practice site to engage in registry data collection, electronic prescribing and patient self-management.

Element A: Patient Care Registries

The organization uses patient information and clinical data to maintain registries retrievable by practitioners at the practice site for at least:

1. **A first preventive care service**
2. **A second preventive care service**
3. **A third preventive care service**
4. **A first chronic or acute care condition**
5. **A second chronic or acute care condition**
6. **A third chronic or acute care condition.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process, Materials

Scope of review

Explanation

Registries

Patient registries include data that can assist practitioners in proactively tracking and identifying patient care needs. Registries must be capable of generating action lists for care needs such as overdue or missing services and clinical indicators that fall outside of target ranges. Alerts must be based on evidence-based guidelines.

Information for preventive care needs and chronic or acute conditions can be stored in a single registry or in multiple condition-specific registries.

The organization must provide access to registry data to practitioners. Organizations may do this by providing regularly updated paper action lists to practitioners or direct electronic access to registry data.

NCQA reviews the organizations documented process for providing access to registry data to practitioners. The documented process must include:

- The preventive care services and chronic or acute care needs captured in the registry. NCQA will review this to determine whether the organization maintains registries for at least three preventive care services and at least three chronic conditions or acute care needs.
- A description of the practitioners to whom access is given
- How the organization makes registry data available to practitioners (i.e. electronic access or paper action lists). If the organization sends paper action lists, it documents the frequency the reports are updated and distributed to

practitioners.

- A description of the information included on the action lists. The organization may submit a sample action list or screen shot as evidence.

Examples None.

Element B: Electronic Prescribing

The organization uses an electronic prescription system with the following capabilities:

1. **Electronic system used to generate at least 75% of prescriptions**
2. **Electronic system generates and transmits at least 40% of eligible prescriptions to pharmacies**
3. **Electronic system is integrated with patient medical records**
4. **Electronic system includes patient-specific checks for drug-drug and drug allergy interactions**
5. **Electronic system alerts prescriber to generic alternatives**
6. **Electronic system alerts prescriber to formulary status.**

Scoring

100%	80%	50%	20%	0%

Data source

Materials, Reports

Scope of review

Explanation

Prescribing errors are the largest identified source of preventable hospital medical error. Electronic prescribing can significantly reduce the medication error rate and potential ham to patients.

NCQA reviews reports or screen shots from the organization's electronic prescribing system demonstrating the following:

- At least 75% of eligible prescriptions are generated electronically, including new prescriptions and renewals. If all of the practice's prescriptions are written electronically, the practice must provide a report showing use of the system for a specified percentage of patients.
- The electronic-prescribing system generates and transmits at least 40% of eligible prescriptions directly to the pharmacy.
- Integration between the electronic prescribing system and the patient's medical record allows the e-prescribing system to identify documented allergies in the patient's record and creates a more accurate list of the medications patients are prescribed.
- The system identifies and alerts the clinician, when a new prescription request is entered, to potentially harmful interactions between drugs and patient allergies to the drug. The term **patient-specific** refers to information that is related or linked to data on a particular patient.
- The system alerts the clinician to cost-effective generic options.
- The system connects with or downloads the formulary for the patient's health plan to identify drugs covered by insurance and the drug's copayment tier, if applicable.

An e-prescribing system that includes e-faxing is acceptable as long as it is not a hand-written prescription.

Examples

None.

Element D: Self-Management Support

The organization provides resources to support patient self-management

1. **Provides educational resources to assist in self-management**
2. **Provides self-management tools that enables patients/families to record self-care results**
3. **Provides access to a personal health record**
4. **Provides or connects patients/families to self-management support programs and resources**

Scoring

100%	80%	50%	20%	0%

Data source

Materials

Scope of review

Explanation

Self-management support helps the patient better manage their health. Support includes tools or materials that provide relevant information about self-management needs (e.g., patients with coronary artery disease and hypertension receive information about their blood pressure measurement, what the measurement should be and how to lower their blood pressure), and it may allow the patient to actively track relevant self-management goals and progress (e.g., a patient health record, an online tool that allows patients to track how often they measure their blood sugar and the results).

NCQA reviews materials from the organization for evidence that it makes self-management support resources available.

Examples

Educational materials:

- Printed condition specific information
- Web-based condition specific information.

CT 1: Information Exchange for Care Coordination and Transitions

The organization can facilitate timely information exchange between primary care, specialty care and hospitals for care coordination and transitions.

Intent

The organization has a coordinated system of care between multiple providers to offer integrated, timely and effective care.

Element A: Coordinating Information Exchange

To coordinate care for its patients, the organization has a documented process for exchanging health information across care settings, which includes:

1. **An agreement with providers (e.g., primary care, specialty, hospitals) about exchanging information**
2. **The types of information to be exchanged**
3. **Timeframes for exchanging information**
4. **How it facilitates referrals.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process

Scope of review

Look-back period

Explanation

Care coordination is a key aspect in improving the quality of care patients receive. Care coordination is a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions and sites are met over time. Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe and high-quality patient experiences and improved health care outcomes (National Quality Forum definition).

This element assesses whether the organization has the capability to coordinate the sharing of relevant medical information efficiently across different health care settings.

Agreement

The organization has an agreement with practitioners and providers to exchange information in a timely manner when there are changes in the patient's care with the relevant care provider. The agreement should include procedures for sharing information between both participating practitioners and providers AND non-participating practitioners and providers. The care providers may include, but are not limited to, primary care practitioners, specialists and hospitals.

Facilitation of referrals

The organization has a process specifying how it facilitates the referral of its patients to participating practitioners and providers as well as to non-participating practitioners and providers. The documented process should describe how the organization shares information between participating and non-participating entities. The organization must

have a process explaining the types of referrals it performs.

Types of information exchanged

The documented process must include the types of information that must be exchanged. The organization can determine what types of information are relevant for exchange between the health care settings. The organization may expect any of the following types of information to be exchanged:

- a summary of care provided
- care plan and medication updates
- laboratory results or
- treatment recommendations.

Timeframe for exchanging information

The organization has a documented process describing how it defines the timeframes for exchanging information across various care settings.

Examples None.

Element B: Process for Transitions

To facilitate transitions the organization has a documented process to:

1. **Identify patients who transition between settings**
2. **Share clinical information received from the first setting with the second setting and primary care practitioner**
3. **Communicate with hospitals to exchange information about patients during hospitalization**
4. **Obtain patient discharge summaries from hospitals, emergency departments and other facilities**
5. **Contact patients or families following transitions within an appropriate timeframe for appropriate follow-up care**
6. **Electronically exchange key clinical information with facilities**
7. **Provide an electronic summary of care record to other care settings**
8. **Track the status of transitions, including the timing of information exchange.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process

Scope of review

Explanation

The organization has the capability to facilitate safe transitions of its patients from one setting (e.g. hospital, rehabilitation facility, patients home) to another care setting. The organization has policies that outline its procedures for managing safe transitions between settings.

Transitions

The organization can describe how it identifies which patients have had planned or unplanned transitions. A **transition** is the movement of a patient from one care setting to another as the patient's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery. **Planned transitions** include elective surgery or a decision to enter a long-term care facility.

Sharing and obtaining information

The organization's documented process explains how the setting that receives the patient obtains relevant clinical information from the first setting. The documented process also addresses that the information shared between providers should be appropriate for the patient's care. The organization has a process regarding how they obtain patient discharge summaries from hospitals, emergency departments or other health care facilities.

Follow-up with patients

The organization instead contacts patients to evaluate their status and to make a follow-up appointment if appropriate. Proactive contact includes assisting patients with appropriate care to prevent worsening of their conditions and encourages follow-up care.

Communication during hospitalizations

The organization develops a two-way communication plan with hospitals to exchange information about hospitalized patients enabling better coordinated care during and post-hospitalization.

Electronic exchange and summaries of care

The organization able to show that it can electronically exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient authorized entities and with facilities (for example, hospitals, emergency rooms, extended care facilities, nursing homes or others). The organization can provide an electronic summary of the patient record to other care settings.

Tracking transitions

The organization also has the ability to track the status of transitions, such as when the transition occurred and when it expects to receive information about the transition.

Examples None.

Element C: Follow-Up After Transitions

The organization at least annually reviews transitions to determine if transitions were performed safely and efficiently.

Scoring	100%	80%	50%	20%	0%

Data source

Documented process, Report

Scope of review

Explanation

Follow-up after transitions

NCQA reviews for evidence that the organization has a documented process and demonstrates that it reviews when and how it follows up with providers after a transition has occurred.

Examples

- A policy for reviewing a transition from a hospital to a skilled nursing facility
- A monthly report reviewing completed transitions.

Element D: Timely Information Exchange

The organization determines if timely information exchange occurs between providers for care coordination and care transitions by:

1. **Having a follow-up process**
2. **Reviewing whether timely information exchanged occurred.**

Scoring	100%	80%	50%	20%	0%

Data source	Documented process, Reports
Scope of review	
Explanation	NCQA reviews for evidence that the organization has a follow-up process to determine if providers have received information within a specified timeframe. The documented process describes when and how the organization tracks whether information exchanges occurred. The organization monitors that coordination and transition activities have occurred according to its established timeframes.
Examples	None.

Element D: Follow-Up After Transitions

The organization at least annually reviews transitions to determine if transitions were performed safely and efficiently.

Scoring	100%	80%	50%	20%	0%

Data source

Documented process, Report

Scope of review

Explanation

Follow-up after transitions

NCQA reviews for evidence that the organization has a documented process for reviewing when and how it follows up with providers after a transition has occurred. The organization demonstrates that it reviews the transitions through reports.

Examples

- A policy for reviewing a transition from a hospital to a skilled nursing facility
- A monthly report reviewing completed transitions.

RR 1: Patient Rights and Responsibilities

The organization states its commitment to treating patients in a manner that respects their rights, its expectations of patients' responsibilities, and privacy. A method is provided for patients to provide complaints and restrict access to data.

Intent

The organization recognizes the specific needs of and maintains a mutually respectful relationship with patients.

Element A: Rights and Responsibilities Statement

The organization's member rights and responsibilities statement specifies that patients have:

1. **A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities**
2. **A right to be treated with respect and recognition of their dignity and their right to privacy**
3. **A right to participate with practitioners in making decisions about their health care**
4. **A right to voice complaints or appeals about the organization or the care it provides**
5. **A responsibility to supply information that they have that the organization and its practitioners and providers need in order to provide care**
6. **A responsibility to follow plans and instructions for care that they have agreed to with their practitioners**
7. **A responsibility to participate in developing a care management plan and carrying it out.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process, Materials

Scope of review

Look-back period

Explanation

Documentation
NCQA reviews documented process or materials for evidence that the organization has a member rights and responsibility policy.

The rights and responsibilities statement may take the form of a written statement, correspondence or formal documentation of a policy.

Factor 4 requires that the organization has no policies restricting dialogue between practitioner and patient and that it affirms that it does not direct practitioners to restrict information regarding treatment options.

Examples None.

Element B: Written Policies for Privacy and Confidentiality

The organization implements written policies and procedures for the handling of protected health information (PHI) that address:

1. **Information included in notification of privacy practices**
2. **Access to PHI**
3. **The process for patients to request restrictions on use and disclosure of PHI**
4. **The process for patients to request amendments to PHI**
5. **The process for patients to request an accounting of disclosures of PHI**
6. **Internal protection of oral, written and electronic information across the organization.**

Scoring

100%	80%	50%	20%	0%

Data source

Materials, Reports

Scope of review

Look-back period

Explanation

NCQA and HIPAA
When determining how to align NCQA standards on privacy and confidentiality with HIPAA privacy regulations, NCQA followed these basic guidelines:

- Encompass the regulation within NCQA standards
- Do not become a de facto compliance monitor
- Deviate from HIPAA where necessary.

Compliance with federal regulations and NCQA standards
Compliance with federal regulations means compliance with NCQA standards. There are some instances [(e.g., distribution of privacy policy notifications)] where NCQA is more lenient than the HIPAA regulations. In other instances, NCQA has privacy and confidentiality-related standards where no HIPAA regulations exist (e.g., Web site privacy policies).

NCQA monitors developments in the HIPAA regulations and will modify its standards, if necessary, to ensure that they do not conflict with regulations and that they stay within the above guidelines.

Routine consent and notifications of privacy practices
The organization may obtain routine consent from patients, but may choose not to do so. Whether consent is used or not, the organization must provide a standard notification of privacy practices to all patients upon assignment to the organization.

Patient requests related to PHI
Protected health information (PHI) is individually identifiable health information that is transmitted by electronic media or transmitted or maintained in any other form or medium (Federal Register, vol. 65, no. 250, section 164.501). Examples of PHI include medical records, claims and other administrative data that are personally identifiable. The organization must have a documented process to receive, analyze, resolve and, when approved, comply with patient requests to restrict use and disclosure of their PHI.

The organization does not need to approve all such requests, but it must have a process for evaluating each request and deciding on a course of action. The organization must also have a documented process to receive and respond to patient requests to:

- Amend their PHI
- Obtain accounts of the organization or delegate's disclosures of their PHI (except for disclosures for treatment, payment and health care operations or disclosures for patient provided authorization).

Protecting PHI

The organization's policies must state how it protects the privacy of protected health information in oral, written and electronic form from unauthorized or inappropriate use. Policies must state that when the organization transmits PHI to another organization, as permitted by law, the PHI is protected according to the organization's specifications.

Examples None.

Element C: Physical and Electronic Access

The organization has implemented a process for managing physical and electronic access to sensitive information, including:

1. **Protections for physical facility access**
2. **Protections for electronic access**
3. **Media and device controls**
4. **Physical safeguards for workstations**
5. **Procedures for allowing and removing access according to role-based employment.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process

Scope of review

Look-back period

Explanation

Physical and electronic access
Securing and protecting sensitive information includes basic protections for physical facilities and electronic systems that contain sensitive information in any form. Sensitive information includes PHI, as defined under the HIPAA regulations, and other health information that eligible individuals would reasonably want to keep private. The organization has a documented process for physical and electronic protection at all sites, and controls access to those sites for both workforce members and visitors. The process includes procedures to determine that only appropriate individuals have access to controlled sites or areas and procedures to determine that all access controls are functioning and effective. Physical facilities include buildings and offices, as well as hardware such as fax machines, copy machines and workstations that may be used to access sensitive information on the organization's premises.

Because sensitive information may not be confined to systems contained on the organization's premises, the organization must have documented processes that govern and track the receipt, removal and access to devices and media that include sensitive information or which may be used to access sensitive information. The documented process covers media (i.e., tapes, diskettes, CDs) moving into and out of a facility, devices and hardware (e.g., laptops) movement; data storage; disposal; and, re-use of media and devices.

Identification of workstations used to access sensitive information in electronic format is critical to protecting such information. The organization must have a process in place to minimize the risk of unauthorized access to sensitive information from workstations.

To minimize the risk of impermissible access to sensitive information, the organization must have a process to control access to such information by employees whose jobs require access. A termination procedure is important to prevent the possibility of unauthorized access to secure data by staff that are no longer authorized to access

the data.

Examples

None.

Element D: Policies and Procedures for Complaints

The organization has written policies and procedures to:

1. **Receive and document complaints from patients**
2. **Investigate relevant patient complaints**
3. **For complaints that are not relevant, triage and refer them to the appropriate parties and to the payer, if applicable**
4. **Respond to patient complaints**
5. **Notify and update patients on the progress of the investigation**
6. **Resolve patient complaints**
7. **Meet timeliness standards for responding to and resolving patient complaints.**

Scoring

100%	80%	50%	20%	0%

Data source

Documented process

Scope of review

Explanation

A formal complaint system provides patients with a method for addressing dissatisfaction with the organization.

Complaints are oral or written expressions of dissatisfaction. The organization may use other terms for this level of interaction with patients, such as *grievances* or *concerns*. NCQA refers to patients' initial expression of concern as "complaints."

Investigation
The organization must research and document all issues relevant to the complaint. Complaints should relate to the organization's actions and not to a problem with the client, such as a problem with coverage.

Patient notification
The organization must notify patients in a timely manner when an issue is resolved. Patients may be notified by telephone if a staff member records the notification electronically or in writing.

There may be some complaints that the organization cannot resolve immediately, or for which it cannot inform patients of the final disposition. In these cases, and in all cases related to quality of care, at a minimum the organization must notify patients that the complaint was received and investigated.

Timeliness
The organization must determine timeliness standards for resolving complaints**.**

Note:
NCQA anticipates a documented process should be sufficient data sources at this time but may include file review in the future.

Examples

Information in complaint policies and procedures

- How the organization receives patient complaints (e.g., telephone, mail, fax, onsite visit)

- How complaints are logged into the system, including documentation of the patient's demographic information, the nature of the complaint and its resolution
- How the organization resolves complaints, including triage to the appropriate department (e.g., initial contact, follow-up)
- How the organization categorizes different types of complaints (e.g., routine inquiries and dissatisfaction)
- The turnaround time for resolving different types of complaints
- Patient notification of the resolution.

PR 1: Performance Reporting

The organization measures and reports clinical quality of care, patient experience and resource stewardship.

Intent

The organization strives to improve the quality of its services by measuring its performance using valid measures and making results available to the public and participating providers.

Element A: Core Performance Measures

At least annually, the organization monitors the following performance measures:

1. At least three preventive care measures
2. At least five chronic care clinical measures
3. At least one acute care clinical measures
4. At least two measures of expenditures, resource use, or appropriateness
5. Patient experience surveys.

Scoring	100%	80%	50%	20%	0%

Data source Reports

Scope of review

Look-back period

Explanation

At least annually, the organization assesses the population served by its organization and monitors the core performance measures. **Annual** is defined here as at least every 12 months, with a 2-month grace period (14 months).

For each measure, the organization must use valid data and methodology to produce a quantitative result. Each measure includes the entire relevant population of patients for whom the organization has responsibility, not just the patients who have had an office visit. The organization may use a sample if it shows that the sample was drawn from the entire population.

Core Performance Measures
Performance monitoring is a necessary component of an organization's quality improvement strategy. The core performance measures are the minimum set of measures organizations must monitor and include measures of clinical quality, patient experience, and cost. Examples of measures in each category may be found in, Table 1: ACO Performance Measures.

NCQA does not require the use of standardized ACO Performance Measures (specified in Appendix A: ACO Measure Table) to meet this element, but organizations that collect these measures meet the requirement to use valid data and methodology. If the organization states that it is using ACO Performance Measures to meet this element, NCQA verifies the measure methodology. At times, organizations depart from NCQA methodology by defining the population differently or by measuring a different indicator with the same population. Although variations mean that the resulting measure is not an

ACO Performance Measure, it may be acceptable for this element if the methodology is valid.

Data and methodology
Methods used by the organization to capture and analyze data must produce valid findings for internal tracking and quality improvement. NCQA does not require the use of a particular methodology for data collection. Many organizations rely on information from patients or practitioners to track testing results or adherence to medications and treatment plans. Data sources include:

- Patient surveys
- Administrative data from the organization or its health plan clients, such pharmacy, lab or encounter data or claims data showing hospital use
- Clinical data from sources including laboratory or radiology results
- Data collected by the organization through its contacts with patients or practitioners, including data from paper or electronic medical records.

The organization must explain the data collection methods it used. NCQA evaluates how the organization identified the population to be studied, the data sources, the data collection techniques and the sampling techniques, if sampling was used. If sampling was used, data must capture information for a minimum of 50% of the ACO's patients. The organization must note any limitations (e.g., incomplete claims data, missing treatment records or inaccurate coding) in the methodology. NCQA evaluates limitations and verifies whether the organization identified the limitations in its analysis.

If the organization states that it is using non-HEDIS Performance Measures to meet this element, NCQA verifies the Performance Measure methodology.

Population-based measurement
NCQA reviews technical specifications for measures to verify that measures pertain to the entire population for which the organization has responsibility. When producing measures, the organization may:

- Use a sample, particularly for patient surveys, if it shows that the sample is drawn from the entire population
- Produce a measure by stratification level, such as HbA1c rates for three acuity levels of diabetics.

Note:
NCQA would like any additional feedback on Appendix A; ACO Measure Table during the public comment period.

Examples None.

Element B: Performance Measure Data Sources

The organization uses data from the following sources to determine its performance measure rates:

1. Outpatient claims or encounter data from participating practitioners and providers
2. Inpatient claims or encounter data from participating practitioners and providers
3. Outpatient claims or encounter data from non-participating practitioners and providers
4. Inpatient claims or encounter data from non-participating practitioners and providers
5. Electronic health records
6. Pharmacy data
7. Laboratory Results.

Scoring	100%	80%	50%	20%	0%

Data source Materials, Reports

Scope of review

Explanation Using data from a variety of data sources can help the organization develop performance reports that accurately reflect the care received by its patients.

NCQA reviews the organization's methodology for determining performance measure rates for evidence of the data sources used. As some data types are not applicable to every measure, NCQA reviews all measure methodologies to determine whether they collectively demonstrate the use of all data types.

If multiple methodologies are rolled up into one data source via Electronic health records (EHR), NCQA will review the components of the EHR for each data source.

Examples None.

Element C: Practitioner Performance Reporting

The organization:

1. **Has a documented process for distributing practice-level performance reports to participating practitioners**
2. **Distributes practice-level performance reports to primary care practitioners**
3. **Distributes practice-level performance reports to high-volume SCPs.**

Scoring	100%	80%	50%	20%	0%

Data source

Documented process, Reports

Scope of review

Explanation

NCQA reviews the organizations documented process for distributing practice-level performance reports to participating practitioners. The documented process must include the measures included in the reports, the practitioners to whom the report is distributed (e.g. primary care practices, high-volume specialists), the level the measures are reported (e.g. practice level, individual practitioner level) and the frequency the reports are distributed.

NCQA reviews a sample of up to three reports that were distributed to primary care providers and high-volume SCPs during the review period. Documentation (i.e., materials or reports) must include:

- Measure results at the practice level
- Measure results at the organization level
- Measure results in comparison to a benchmark or goal
- The definition of the population included in the denominator for each measure
- A description of how individuals are placed in the numerator for each measure
- A description of the time period each measure covers and how it impacts inclusions and exclusions in the numerator and denominator.

NCQA does not review ad-hoc requests for measure reports the organization receives from practices/practitioners.

Transparency in reporting
To facilitate understanding of the results, the organization includes detailed explanations of the measures in reports distributed to practitioners. Explanations include:

- The definition of the population included in the denominator
- A description of how individuals are placed in the numerator
- A description of the time period and how it impacts inclusions and exclusions in the numerator and denominator.

NCQA may publicly report whether the organization is transparent in reporting to clients, but does not disclose the details of the organization's methodology.

Examples

Items included in the performance reports may be: physician-ordered services, such as consultations, imaging, ancillary services, procedures and devices utilization.

Element D: Reporting Performance Publically

At least annually, the organization publically reports performance valid and reliable results for:

1. **Clinical quality**
2. **Patient Experience**
3. **Expenditures, Resource use, or Appropriateness.**

Scoring	100%	80%	50%	20%	0%

Data source Documented process, Materials

Scope of review

Explanation The practice publically reports via one or more of the following methods:

- Submission to NCQA and publication in an ACO Quality Compass
- Submission to CMS, for measures of Meaningful use
- Publication materials distributed to patients
- Publication materials distributed to affiliated organizations (i.e. health plan partners, hospital partners, if applicable)
- Posting of reports on organization website.

NCQA does not specify the performance measures to be reported. NCQA does not specify the quantity of measures to be reported.

Valid and reliable results

For each measure reported, the organization must use valid data and methodology to produce a quantitative result. Each measure includes the entire relevant population of patients for whom the organization has responsibility, not just the patients who have had an office visit. The organization may use a sample if it shows that the sample was drawn from the entire population.

NCQA does not require the use of ACO Performance Measures (specified in Table 1: ACO Measurement) to meet this element, but organizations that collect these measures meet the requirement to use valid data and methodology. If the organization states that it is using ACO Performance Measures to meet this element, NCQA verifies the measure methodology. At times, organizations depart from NCQA methodology by defining the population differently or by measuring a different indicator with the same population. Although variations mean that the resulting measure is not an ACO Performance Measure, it may be acceptable for this element if the methodology is valid.

Examples None.

PR 2: Quality Improvement

At least annually, the organization measures and analyzes the results of performance measurement activities and takes action to improve effectiveness in key areas.

Intent

Sound, quantitative measurement and analysis establish a basis for quality improvement and tracking results.

Element A: Clinical Quality and Cost Performance Improvement

At least annually, the organization:

1. **Conducts a quantitative analysis of performance including a comparison with a benchmark or goal using clinical and cost data**
2. **Conducts a qualitative analysis of performance using clinical and cost data**
3. **Identifies at least two opportunities for improvement**
4. **Implements at least two interventions per opportunity to improve selected opportunities**
5. **Measures the effectiveness of interventions to improve each measure.**

Scoring	100%	80%	50%	20%	0%

Data source Materials, Reports

Scope of review

Look-back period

Explanation

Quantitative analysis and comparison to benchmarks
The organization conducts an annual qualitative analysis of performance results from PR 1, Element A (if applicable).

Analysis of findings must include a first-level, quantitative analysis of the data, including a comparison of results with the goal or benchmark and past performance, if a previous measurement was performed. Tests of statistical significance are not required, but may be useful when analyzing trends.

Staff members or other individuals who are specialists in data analysis often develop or help develop first-level analyses. Analyses must go beyond data display and simple reporting of results.

A **performance goal** is the desired level of achievement that the organization sets for itself as its standard of care.

A **benchmark** is the measure of best performance external to the organization for a particular measure. The benchmark may be taken from the industry best-practice or from the best performance in a corporate structure or a specific geographical area.

Analysis should result in setting priorities for the selection of opportunities for improvement.

Comparability and reporting
The intent of this element is to establish a basis for sound outcomes measurement while acknowledging that different ACO programs have widely varying population bases, enrollment methods and access to data. These factors vary even among different client groups within one program; therefore, NCQA accepts measurement by

client group.

The organization may produce each measure separately for each client. In this case, NCQA reviews measurements for a sample of up to three clients. If the organization uses HEDIS Performance Measures, data reporting must follow guidelines outlined in the technical specifications.

Qualitative analysis
The purpose of qualitative analysis is to identify reasons for measurement results and potential barriers to improvement. This is especially important when results do not meet the goal or benchmark identified by the organization. This phase of the analysis is critical to developing effective interventions. It must include staff patients who understand processes of care and potential barriers to improvement.

Before developing an action plan that addresses the organization's specific needs, QI staff may need to collect further data from practitioners or patients. Barriers to data collection are not considered barriers to improvement.

Selecting measures for improvement and identifying opportunities
Using information from the qualitative analysis conducted, the organization identifies categories of quality measure rates that it believes it can improve.

Implementing interventions
The organization must design interventions that address barriers or specific circumstances. Actions implemented by the organization must be of sufficient strength and specificity to have had the potential to contribute to a measurable improvement when measurement is repeated. Actions must not be so generic that they could have been initiated (or would have been initiated) in the absence of a QI program.

NCQA evaluates the strength of each intervention by assessing the following.
• Is the intervention sufficiently strong that it has some likelihood of making a positive impact?
• Is the intervention related specifically to the identified barriers to improvement or to the causes of not meeting the goal?
• Did the intervention begin early enough to have affected performance?
If there is a series of interventions, the timing of each may influence the outcome.

Pilot programs
In some cases, the organization may elect to conduct interventions as part of a pilot program. A pilot program may be appropriate when testing original interventions that have not been implemented elsewhere, are complicated or expensive or respond specifically to the results of qualitative analysis. The organization may test such interventions on a smaller segment of the population before extending the action to the entire universe of patients, but it must roll out the program to the entire patient population to meet this element. Full rollout may be demonstrated by letters to patients or practitioners announcing expansion or containing detailed work plans.

Measuring effectiveness
The organization must determine if its interventions improved the quality of care to patients. Each evaluation must be designed in measurable terms so comparison can be made with previous findings. The organization must allow sufficient time to elapse before each effectiveness evaluation. Measurement does not need to demonstrate statistically significant or meaningful improvement to meet the requirements of this element.

Evaluation of effectiveness may measure either intermediate or ultimate outcomes. In some cases, intermediate measures of the intervention may give the organization important information, even if the measurements do not demonstrate improvement.

Exceptions:

Factor 5 is NA for Initial Surveys.

NOTE FOR PUBLIC COMMENT: NCQA envisions this element will remain in the ACO criteria until a majority of organizations being surveyed demonstrate good data collection. At that point, NCQA may move to require performance benchmarking.

Examples None.

Element B: Patient Experience Improvement

At least annually, the organization:

1. **Conducts a quantitative analysis of patient experience results including a comparison with a benchmark or goal**
2. **Conducts a qualitative analysis**
3. **Identifies at least two opportunities for improvement**
4. **Implements at least two interventions to improve selected patient experience opportunities**
5. **Measures the effectiveness of interventions to improve each measure.**

Scoring

100%	80%	50%	20%	0%

Data source

Scope of review

Explanation

Analysis should result in setting priorities for the selection of opportunities for improvement.

Quantitative analysis and comparison to benchmarks
The organization conducts an annual qualitative analysis of patient experience results from PR 1, Elements A and B (if applicable) using the CAHPS CG survey.

Analysis of findings must include a first-level, quantitative analysis of the data, including a comparison of results with the goal or benchmark and past performance, if a previous measurement was performed. Tests of statistical significance are not required, but may be useful when analyzing trends.

Staff patients or other individuals who are specialists in data analysis often develop or help develop first-level analyses. Analyses must go beyond data display and simple reporting of results.

A **performance goal** is the desired level of achievement that the organization sets for itself as its standard of care. NCQA expects this goal will be related to national or regional benchmarks. Evidence of benchmarks need to be submitted to NCQA.

A **benchmark** is the measure of best performance external to the organization for a particular measure. The benchmark may be taken from the industry best-practice or from the best performance in a corporate structure or a specific geographical area.

Comparability and reporting
The intent of this element is to establish a basis for sound outcomes measurement while acknowledging that different ACO programs have widely varying population bases, enrollment methods and access to data. These factors vary even among different client groups within one program; therefore, NCQA accepts measurement by client group.

The organization may produce each measure separately for each client. In this case, NCQA reviews measurements for a sample of up to three clients. If the organization uses CAHPS CG, data reporting must follow guidelines outlined in the technical specifications.

Qualitative analysis
The purpose of qualitative analysis is to identify reasons for measurement results and potential barriers to improvement. This is especially important when results do not meet the goal or benchmark identified by the organization. This phase of the analysis is

critical to developing effective interventions. It must include staff patients who understand processes of care and potential barriers to improvement.

Before developing an action plan that addresses the organization's specific needs, QI staff may need to collect further data from practitioners or patients. Barriers to data collection are not considered barriers to improvement.

Selecting measures for improvement and identifying opportunities
Using information from the qualitative analysis conducted, the organization identifies quality measure rates that it believes it can improve. NCQA encourages use of CAHPS CG survey and selection of CAHPS measures for improvement.

Implementing interventions
The organization must design interventions that address barriers or specific circumstances. Actions implemented by the organization must be of sufficient strength and specificity to have had the potential to contribute to a measurable improvement when measurement is repeated. Actions must not be so generic that they could have been initiated (or would have been initiated) in the absence of a QI program.

NCQA evaluates the strength of each intervention by assessing the following.
• Is the intervention sufficiently strong that it has some likelihood of making a positive impact?
• Is the intervention related specifically to the identified barriers to improvement or to the causes of not meeting the goal?
• Did the intervention begin early enough to have affected performance?
If there is a series of interventions, the timing of each may influence the outcome.

Pilot programs
In some cases, the organization may elect to conduct interventions as part of a pilot program. A pilot program may be appropriate when testing original interventions that have not been implemented elsewhere, are complicated or expensive or respond specifically to the results of qualitative analysis. The organization may test such interventions on a smaller segment of the population before extending the action to the entire universe of patients, but it must roll out the program to the entire patient population to meet this element. Full rollout may be demonstrated by letters to patients or practitioners announcing expansion or containing detailed work plans.

Measuring effectiveness
The organization must determine if its interventions improved the quality of care to patients. Each evaluation must be designed in measurable terms so comparison can be made with previous findings. The organization must allow sufficient time to elapse before each effectiveness evaluation. Measurement does not need to demonstrate statistically significant or meaningful improvement to meet the requirements of this element.

Evaluation of effectiveness may measure either intermediate or ultimate outcomes. In some cases, intermediate measures of the intervention may give the organization important information, even if the measurements do not demonstrate improvement.

Examples None.