NCQA Criteria For PCMH	Content		HYH Component(s) Offered
Core (red) Elective (black)			
Knowing and Managing			
1. KM 01	Predominant practice conditions		BP, DM, CAD, respiratory, obesity
2. KM 02A	Medical History of Patient Medical History of Family		BP, DM, CAD, respiratory, obesity CAD, DM, cancer, cholesterol, other
3. KM 02B	Mental Health/Substance Use of Patient		emotional bothers, alcohol use, tobacco
4. KM 02C	Family Characteristics Social Characteristics		Domestic violence screen Social Support
5. KM 02D	Communication Needs		-
6. KM 02E	Behaviors Affecting Health		Exercise, Nutrition, Seat belts
7. KM 02F	Social Functioning		Social functioning
8. KM 02G	Social Determinant of Health		Financial Insufficiency
9. KM 02H	Developmental Screen Peds		-
10. KM 02I	Advance Care Planning		DPA designee, written instrument
11. KM 03	Depression/Anxiety Screen		Provider aware, explanation and improved with treatment
12. KM 04	Anxiety Screening Alcohol Screening		Provider aware, explanation and improved with treatment Alcohol >10/w, told to reduce
13. KM 05	Oral health screening		-
14. KM 06	Predominant practice conditions		Summary report (htn, dm, CAD, respiratory, obesity)
15. KM 07	Social determinant of health		Financial insufficiency
16. KM 08	Evaluate Pop-Health Literacy Comm		-
17. KM09-10	Ass Pop Racial/Ethn Divers & Lang		-
18. KM11A	Ass Pop Health Disparities		HYH disparity measure (choice)
19. KM11B,C	Health Literacy or Cult Competency		-
20. KM12	Proactive Reminders		-
21. KM13	Excellence Benchmarked Program		HYH HTN, DM?
22. KM14	Medication Reconciliation		-
23. KM15	Updated Med List		-
24. KM16	Assess Pt Knowledge of New Meds		-
25. KM17	Assess Barriers to Med Adherence		
26. KM18	Check PDMP prior to prescribing		
27. KM19	Use Claims Data Addr Med Adherence		
28. KM20A	Use Evidence Based CDS – mental health	respond to 4 (options A-G)	HYH – emotional screening and f/u data
29. KM20B	Use Evidence Based CDS – alcohol use		HYH – alcohol use and f/u MI
30. KM20C	Use Evidence Based CDS – chronic cond		Hypertension AND Diabetes
31. KM20D	Use Evidence Based CDS- acute condition		-
32. KM20E	Use Evidence Based CDS - lifestyle		Smoking, Obesity/nutrition
33. KM20F	Use Evidence Based CDS - preventive		Pneumovax
34. KM20G	Use Evidence Based CDS – overuse		-
35. KM21	Use Pop Info to Prioritize Comm Resources		Sections on: ‘ bothered by’ , ‘concerned about’, ‘ aids used’ , ‘habits’, ‘ diagnoses’
36. KM22	Access to Education		Action Plan chronic conditions; https://howsyourhealth.com/pblmslv/
37. KM23	Provides Oral Health Resources		-
38. KM24	Adopts Shared Decision Making		-
39. KM25	Partners with Schools or other Agencies		-
40. KM26	Updated List of Community Resources		Community resources- HYH action plan

41. KM27	Assesses Utility of Resources (above)		-
42. KM28	Regular Case Conf (outside practice)		-
Care Management			
43. CM1-2	Care Management/Plans		Activate registry Report: total # surveys/total active pts seen in measurement year Virtual review: registry, action plans and integration of use into patient plan
44. CM 03	Risk Stratification		If using registry this should satisfy
45. CM 4-5	Care Plans		If responding to care plans this should satisfy
46. CM 6-8	Patient preferences, goals, barriers SMS		Same as above
47. CM9	Share care plan across facilities		? possible HYH interation with RI HIE
Access and Continuity			
Access		Process + access score as evidence	
48. AC 01	Survey access needs, same day/urgent during and after hours, phone advice		Practice access score > x% gives credit
49. AC 02	Provide same day appointments		Practice access score > x% gives credit
50. AC 03	Provide appnts outside usual business hrs		Practice access score > x% gives credit
51. AC 04	Provide timely clinical advice by phone		Practice access score > x% gives credit
52. AC 05	Document concordant clinical advice in chart		Practice access score > x% gives credit
53. AC 06	Provide appnt by phone or other tech		Practice access score > x% gives credit
54. AC 07	Sec pt request rxn,appnt,refill,result	No process doc required	Practice access score > x% gives credit
55. AC 08	Secure 2 way communication		Practice access score > x% gives credit
56. AC 09	Access disparities		Access disparity between “haves” and “have-nots”
Continuity			
57. AC10	Pick or change PCP	Process only (solos exempt)	Practice continuity score >x% gives credit
58. AC11	Monitor % visits with PCP/team	Evidence only	Practice continuity score >x% gives credit
59. AC12	Continuity medical record when office closed	Process only	-
60. AC13	Reviews and manages panel size	Process and report	Practice continuity score >x% gives credit
61. AC14	Rev and rec panel based on outside entity		-
Performance and Quality Improvement			
62. QI 01A	Immunizations	5 total (at least one each A-D)	69+ pneumonia vaccine rate
63. QI 01B	Preventive Care Measure		colon cancer screen rate OR mammogram rate
64. QI 01C	Chronic Care Measure		Blood pressure >150 OR Blood sugar > 140
65. QI 01D	Behavioral Health Measure		Aware of bothersome emotional
66. QI 02A	Care Coordination	2 total (one from each)	Practice coordination score
67. QI 02B	Health Care Costs		Hospital/ER for chronic disease
68. QI 03	Access		Practice access score
69. QI 04A	Patient Experience	Measure 3 of 4 options	
a.	Access		Practice access score
b.	Coordination		Practice coordination score
c.	Self-Management Support		Practice confidence score
d.	Whole Person Care		Practice global care score
70. QI 04B	Qualitative Survey	Elec survey comm not allowed	-
71. QI 05A	Clinical Quality – Disparities		Disparities BP not controlled
72. QI 05B	Patient Experience - Disparities		Disparities global care score
73. QI 06	Uses standardized survey		Refer to HYH entire report
74. QI 07	Obtains feedback from vulnerable population		Refer to HYH entire report disparities
75. QI 08	Sets goals and acts to improve on:	Pick 3 of 4 options	
a.	Immunizations		Pneumovax (or other)

b.	Other Preventive Care		Colon cancer screen or mamm (or other)
c.	Chronic or Acute Care Measures		BP or DM (or other)
d.	Behavioral Health Measures		Emotional (or? Alcohol or Tobacco)
76. QI 09	Sets goals and acts to improve on:	Pick 1 of 2 options	
a.	Hospital/ER use		Current ER/Hosp use for chronic disease
b.	Care coordination		Coordination
77. QI 10	Access Describe Actions/Set Goals		(Access score)
78. QI 11	Confidence Describe Act/Set Goals		(Confidence score)
79. QI 12	Improved Performance (2) QI 8, 9 or 11		(6 -12 month improvement, provider choice metrics)
80. QI 13	Disparities Describe Act/Set Goals		(provider choice)
81. QI 14	Improved Performance (1) Disparities (QI 13)		(provider choice)
Care Coordination and Care Transitions			
82. CC 01	Managing Lab and Imaging Results		-
83. CC 02	Obtaining newborn screens		-
84. CC 03	Protocols to determine testing need		-
85. CC 04	Managing Referrals to Specialists	Describe process	Practice coordination score >x% credit
86. CC 05	Use Clin Prot to determine refer need		-
87. CC 06	IDs specialists used by practice		?Practice coordination score >x% credit
88. CC 07	Use perf input on specialists to refer		-
89. CC 08	Works w/ non BH to set expectations		-
90. CC 09	Works w/ BH to set expectations		-
91. CC 10	Integrates behavioral health into site		-
92. CC 11	Assess specialist response	Process	? Practice coordination score >x% credit
93. CC 12	Co-management arrangements		-
94. CC 13	Engages with pts around cost	Process	% of patients with financial hardship
95. CC 14-16	Care Transitions ER/Hosp		-
96. CC 17-20	Care Coordination Between Sites		-
97. CC 21	Electronic Info Exch/Entity		-
Team Based Care			
98. TC 1-2	Lead Transformation/Structure/Staff		-
99. TC 3-8	Ext PCMH activities, patient input governance, EHR, team meetings clinical/QI, CM for behavioral		-
100. TC 09	Medical home proselytizing		-