

PCMH/ PCSP Requirement for BQPP practices with more than one location:

Practices must have at least one location PCMH certified through NCQA, JACO, or URAC to meet the threshold requirement for BQPP. Additional practice locations are no longer required to complete the PCMH/PCSP certification, however each location's structure must apply the following **core elements** to ensure the practice is following the patient- centered medical home model. This requirement is only for locations under the same group NPI number. Please attest at the end of the document that all locations that are non-PCMH certified follow the core functions outlined below.

PCMH Model Functions:

- I. Team-Based Care and Practice Organization
- II. Knowing and Managing Your Patients
- III. Patient-Centered Access and Continuity
- IV. Care Management and Support
- V. Care Coordination and Care Transitions
- VI. Performance Measurement and Quality Improvement

Team –Based Care and Practice Organization:

- Designates a clinician lead of the medical home & staff person to manage medical home activities
- Defines organizational structure and staff responsibilities/skills to support key PCMH functions
- Has regular patient care team meetings/structured communication process focused on individual patient care
- Involves care team in the practice's performance evaluation and quality improvement activities
- Has a process for informing patients/families/caregivers about the role of the medical home and provides materials

Knowing and Managing Your Patients:

- Documents an up-to-date problem list for each patient with current and active diagnoses
- Comprehensive health assessment includes:
 - Medical history of patient and family
 - Mental health/substance use history of patient and family
 - Family/social/cultural characteristics
 - Communication needs
 - Behaviors affecting health
 - Social functioning
 - Social determinants of health
 - Developmental screening using a standardized tool (NA for practices with no pediatric population under 30 months of age)
 - Advance care planning (NA for pediatric practices)

- Assesses the language and diversity needs of its population
- Conducts depression screenings for adults and adolescents using a standardized tool
- Proactively & routinely identifies populations & reminds them, or their families/caregivers about needed services including preventative, chronic or acute, as well as patients not recently seen
- Reviews and reconciles medications for patients received from care transitions
- Maintains an up-to-date list of medications for patients
- Implements clinical decision support following evidence-based guidelines for care of:
 - Mental health condition
 - Substance use disorder
 - A chronic medical condition
 - An acute condition
 - A condition related to unhealthy behaviors
 - Well child or adult care
 - Overuse/appropriateness issues
- Uses information on the population served to prioritize needed community resources

Patient-Centered Access and Continuity:

- Assesses the access needs and preferences of the patient population
- Provides same-day appointments for routine and urgent care to meet identified patient needs
- Provides routine and urgent appointments outside business hours to meet patient needs
- Provides timely clinical advice by telephone
- Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record
- Helps patients/families/ caregivers select or change a personal clinician
- Sets goals and monitors the percentage of patient visits with the selected clinician or team

Care Management and Support:

- Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):
 - Behavioral health conditions
 - High cost/high utilization
 - Poorly controlled or complex conditions
 - Social determinants of health
 - Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver
- Monitors the percentage of the total patient population identified through its process and criteria
- Establishes a person-centered care plan for patients identified for care management
- Provides a written care plan to the patient/family/caregiver for patients identified for care management

Care Coordination and Care Transitions:

- The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result
- The practice provides important information in referrals to specialists and tracks referrals until the report is received
- Systematically identifies patients with unplanned hospital admissions and ED visits
- Shares clinical information with admitting hospitals and emergency departments
- Contacts patients/families/caregivers for follow-up post hospital admission or ED visit

Performance Measurement and Quality Improvement:

- Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):
 - Immunization measures
 - Other preventive care measures
 - Chronic or acute care clinical measures
 - Behavioral health measures
- Assesses performance on availability of major appointment types to meet patient needs and preferences for access
- Monitors patient experience through surveys to evaluate patient, family, and caregiver experience for access, coordination, communication and whole person care
- Sets goals and acts to improve upon at least three measures across at least three of the four below:
 - Immunization measures
 - Other preventive care measures
 - Chronic or acute care clinical measures
 - Behavioral health measures
- Monitors at least 1 measure of each type of resource stewardship below:
 - Measures related to care coordination
 - Measures affecting health care costs
- Sets goals and acts to improve availability of major appointment types to meet patient needs and preferences
- Sets goals and acts to improve performance on at least one patient experience measure
- Reports practice-level or individual clinician performance results within the practice for process and outcome measures reported by the practice