PCMH Standards and Guidelines

Table of Contents

Table of Contents

Table of Contents

Team-Based Care and Practice Organization (TC)

The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers;

TC Competency A: Practice Organization.

TC 03 (1 Credit) External PCMH Collaborations: The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it is involved in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state,; population-based care or learning collaborative. Participating in an ACO or clinically integrated network would not meet this requirement. Participating in ongoing collaboration with other learn and share best practices with their peers.	**Description of involvement in external collaborative activity**
TC 04 (2 Credits) Patients/Families/Caregivers Involvement in Governance: Patients/families/caregivers are involved in the practice s governance structure or on stakeholder committees.	
GUIDANCE	**EVIDENCE**
The practice either: Creates a role for patients/families/caregivers in the practice s governance structure or Board of Directors, ***or*** Organizes a Patient and Family Advisory Council (PFAC) (stakeholder committee). The practices specifies: How patients/families/caregivers are selected for participation. The role. Frequency of meetings. Patients are more than consumers in their care, they are partners. Involving patients/families/caregivers in the practice s governance can provide additional input to improve patient services and help engage patients in the care they receive from the practice.	**Documented process** ***AND*** **Evidence of implementation**
TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.	
GUIDANCE	**EVIDENCE**
The practice enters the names of the electronic systems it implements. Only systems the practice is actively using should be entered. Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	**CERHT name**

Table of Contents

= Evidence shareable across practice sites

Competency B: Team Communication. Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
GUIDANCE	**EVIDENCE**
The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	**Documented process** ***AND*** **Evidence of implementation** Documented process only
TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice s performance evaluation and quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice describes staff roles and involvement in the performance evaluation and improvement activities. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team in	

Competency C: Medical Home Responsibilities. The practice defines and communicates its role in the medical home model of care.

TC 09 (Core) Medical Home Information: Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.	
GUIDANCE	**EVIDENCE**
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. At minimum, materials include: Names and phone numbers of practice points of contact. Instructions for reaching the practice after office hours. A list of services offered by the practice. How the practice uses evidence-based care. A list of resources for patient education and self-management support. The practice explains to patients the importance of maintaining comprehensive information about their health care. It describes how and where (e.g., specialty practice, primary care office, ED) to access the care they need. 	**Documented process** ***AND*** **Evidence of implementation**

Table of Contents

 = Evidence shareable across practice sites

Knowing and Managing Your Patients (KM)

The practice captures and analyzes information about the patients and community it serves, and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

KM Competency A: Collecting Patient Information.

KM 02 (Core) Comprehensive Health Assessment (all items required): *continued*	
GUIDANCE	**EVIDENCE**
E. Behaviors affecting health. Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental smoke exposure. **F. Social functioning.** Assesses a patient s ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on. **G. Social determinants of health.** Collects information on **social deter/F1 10.02 Tf1BTq8a72**	

Knowing and Managing Your Patients

KM Competency A: Collecting Patient Information.

KM 04 (1 Credit) Behavioral Health Screenings: *continued*	
GUIDANCE	**EVIDENCE**
C. Assessing for substance use can assist the practice to provide needed treatment, referrals and abstinence tools to substance use concerns. Substance use is a growing issue that is impacting all types of patients. Screening supports early intervention and facilitating patients access to the necessary treatments toward sobriety. Available screening tools may include the CAGE AID or DAST-10 instruments, which assess a variety of substance use conditions. Bright Futures recommends clinicians screen all adolescents for substance use during all appropriate acute care visits using developmentally appropriate screening tools. (e.g., CRAFFT or DAST-20). **D.** Pediatric screening for behavioral health is distinct from adult screening and provides opportunities for early interventions that can have lasting effects over a lifetime. This may include tools such as the Behavioral Assessment System for Children (BASC). **E.** The practice uses standardized tools to determine if patients have developed post-traumatic stress disorder (	

KM 04 (1 Credit)

Knowing and Managing Your Patients (KM)

KM Competency B: Patient Diversity.

Competency B: Patient Diversity. The practice uses information about the characteristics of its patient population to provide culturally and linguistically appropriate services.

KM 09 (Core) Diversity: Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.	
GUIDANCE	**EVIDENCE**
The practice collects information on how patients identify in at least three areas that include: 1. Race. 2. Ethnicity. 3. One other aspect of diversity, which may include, but is not limited to, gender identity, sexual orientation, religion, occupation, geographic residence. Assessing the diversity of its population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers, leading to disparities in health outcomes. The practice may collect data directly from patients or may use data about the community (e.g., zip code analysis, community level census data) it serves.	**Report**
KM 10 (Core) Language: Assesses the language needs of its population.	
GUIDANCE	**EVIDENCE**

KM 11 (1 Credit) Population Needs: Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two):

A. Targets population health management on disparities in care.

B. Educates practice staff on health literacy.

C. Educates practice staff in cultural competence.

GUIDANCE	EVIDENCE
The practice recognizes the varied needs of its population and the community it serves, and uses that information to take proactive, health literate, culturally competent approaches to address those needs. The practice: **A.** Identifies disparities in care and implements actions to reduce the disparity. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. **B.** Builds a health-literate organization (e.g., apply universal precautions, provide health literacy training for staff, system redesign to serve patients at different health literacy levels, utilize the AHRQ or Alliance for Health Reform Health Literacy toolkit). Health-literate organizations understand that lack of health literacy leads to poorer health outcomes and compromises patient safety, and act to establish processes that address health literacy to improve patient outcomes. **C.** Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures. It supports practice staff to become respectful and responsive to the health beliefs and cultural and linguistic needs of patients. **Health literacy resources** Institute of Medicine: Ten Attributes of Health Literate Health Care Organizations http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf Agency for Healthcare Research & Quality: Health Literacy Universal Precautions Toolkit: http://www.ahrq.gov/professionals/ quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf Alliance for Health Reform Toolkit: http://www.allhealth.org/publications/Private_health_insurance/Health-Literacy-Toolkit_163.pdf	**A*:* Evidence of implementation**

Competency D: Medication Management.

KM Competency D: Medication Management.

KM 19 (2 Credits) Prescription Claims Data: Systematically obtains prescription claims data in order to assess and address medication adherence.

KM Competency E: Evidence-Based Care.

Competency E: Evidence-Based Care. The practice ensures that it provides effective and efficient care by incorporating evidence-based clinical decision support relevant to patient conditions and the population served.

KM 20 (Core) Clinical Decision Support: *continued*	
GUIDANCE	**EVIDENCE**
C. A chronic medical condition. The practice has evidence-based guidelines it uses for clinical decision support related to at least one chronic	

KM Competency F: Connecting With Community Resources.

Competency F: Connecting With Community Resources. The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support.

KM 21 (Core) Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources.	
GUIDANCE	**EVIDENCE**
The practice identifies needed resources by assessing collected population information. It may assess social determinants, predominant conditions, ED use and other health concerns to prioritize community resources (e.g., food banks, support groups) that support the patient population.	**List of key patient needs and concerns** 
KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.	
GUIDANCE	**EVIDENCE**
Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients. **Educational programs and resources** may include information about a medical condition or condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups). **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings. The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate patients to interact with and learn from each other.	**Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

KM Competency F: Connecting With Community Resources.

KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.	
GUIDANCE	**EVIDENCE**
The practice provides an example of how it provides educational and other resources to patients pertaining to oral health and hygiene. Oral disease is largely preventable with knowledge and attention to hygiene. Poor oral health can complicate the care for chronic conditions such as diabetes and heart disease.	**Evidence of implementation**
KM 24 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	**EVIDENCE**
The care team has, and demonstrates use of, at least three shared decision-making aids that provide detailed information without advising patients to choose one option over another. The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Helping patients understand decision making helps build a trusting relationship. **Shared decision-making resources** International Patient Decision Aid Standards Collaboration (IPDASC) http://ipdas.ohri.ca/index.html Approach https://www.ahrq.gov/professionals	

KM Competency F: Connecting With Community Resources.

Patient-Centered Access and Continuity (AC)

AC 04 (Core) Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.	
GUIDANCE	**EVIDENCE**
Patients can telephone the practice any time of the day or night and receive interactive (from a person, rather than a recorded message) clinical advice. **Clinical advice** refers to a response to an inquiry regarding symptoms, health status or an acute/ chronic condition. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws.	

AC 09 (1 Credit) Equity of Access: Uses information about the population served by the practice to assess equity of access that considers health disparities.	
GUIDANCE	**EVIDENCE**
Knowing whether groups of patients experience differences in access to health care can help practices focus efforts to address the inequity. The practice evaluates whether identified health disparities demonstrate differences in access to care. An example of how a practice may demonstrate this is through a report of how an identified group of patients has lower rates of access to same-day appointments, higher no-show rates, more ED use or lower satisfaction with access than the general patient population. Healthy People 2020 defines **health disparity** particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or	

Competency B: Empanelment and Access to the Medical Record. Practices support

AC 10 (Core) Personal Clinician Selection: Helps patients/families/ caregivers select or change a personal clinician.	
GUIDANCE	**EVIDENCE**
Giving patients/families/caregivers a choice of clinician emphasizes the importance of the ongoing patient-clinician[GUIDA]	

AC Competency B: Empanelment and Access to the Medical Record.

AC 13 (1 Credit) Panel Size Review and Management: Reviews and actively manages panel sizes.	
GUIDANCE	**EVIDENCE**
The practice has a process to review the number of patients assigned to each clinician and balance the Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and provider workload because supply is balanced with patient demand. The American Academy of Family Physicians provides a tool for practices to use when considering and managing panel sizes: http://www.aafp.org/fpm/2007/0400/p44.pdf	**Documented process** ***AND*** **Report** ***Documented process only***
AC 14 (1 Credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments.	
GUIDANCE	

CM 02 (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.	
GUIDANCE	**EVIDENCE**
The practice determines its subset of patients for care management, based on the patient population city to provide services. The practice uses the criteria defined in CM 01 to identify patients who fit defined criteria. The practice must identify at least 30 patients in the numerator. Patients who fit multiple criteria count once in the numerator. Small practices or satellite sites may share a care management population if fewer than 30 patients meet the criteria defined in CM 01.	**Report**
CM 03 (2 Credits) Comprehensive Risk-Stratification Process: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. The practice identifies and directs resources appropriately based on need. **Risk-stratification resources** Stratified Care Management Rubric. CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model.	**Report** 

Table of Contents

 = Evidence shareable across practice sites

CM Competency B: Care Plan Development.

Competency B: Care Plan Development. For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals docum

CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice has a process for consistent development of care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice includes discussions about goals (e.g., patient function/lifestyle goals, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	**Report** ***OR***

CM Competency B: Care Plan Development.

CM 08 (1 Credit) Self-Management Plans: Includes a self-management plan in individual care plans.	
GUIDANCE	**EVIDENCE**

CC Competency A: Diagnostic Test Tracking and Follow-Up.

CC 02 (1 Credit) Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.

CC Competency B: Referrals to Specialists.

Competency B: Referrals to Specialists. The practice provides important information in referrals to specialists and tracks referrals until the report is received.

CC 04 (Core) Referral Management: The practice systematically manages referrals by:
A. Giving the consultant or specialist the clinical question, the required timing and the type of referral.
B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
C. on overdue reports.

GUIDANCE	EVIDENCE
It is important that the practice track patient referrals and communicate patient information to specialists. Tracking and following up on referrals is a way to support patients who obtain services outside the practice. Poor referral communication and lack of follow-up (e.g., to see if a patient kept an appointment with a specialist, to learn about recommendations or test results) can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and	

CC 04 (Core) Referral Management: *continued*	
GUIDANCE	**EVIDENCE**
Clinical findings and current treatment. Follow-up communication or information. care and treatment plan in the referral, in addition to test results and procedures, can reduce conflicts and duplicate services, tests and treatment. If the practice sends the primary care plan with the referral, the specialist can develop a corresponding specialty plan of care. Ideally, the primary care plan, developed in collaboration with the patient/family/caregiver, is coordinated with the specialty plan of care, created in collaboration with the patient/family/caregiver and primary care. **C.** A tracking process includes the date when a referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the practice contacts the office and documents its effort to retrieve the report in a log or an electronic system.	**Documented process** ***AND*** **Evidence of implementation**

CC Competency B: Referrals to Specialists.

CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.	
GUIDANCE	**EVIDENCE**

CC Competency B: Referrals to Specialists.

CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.	
GUIDANCE	**EVIDENCE**
The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided and treatment plan. need. Ongoing assessment and referral monitoring may be helpful in CC 07.	**Documented process** ***AND*** **Report**  ***Documented process only***
CC 12 (1 Credit) Co-Management Arrangements: Documents co-management arrangements in the	
GUIDANCE	**EVIDENCE**
When a particular specialist regularly treats a patient, the primary care clinician and the specialist enter into an agreement that enables safe and efficient co- the agreement, the primary care clinician and specialist share changes in the treatment plan and patient health status, in addition to entering information in the medical record within an agreed-on time frame. The practice must provide three examples of such arrangements.	**Evidence of implementation**
CC 13 (2 Credits) Treatment Options and Costs: Engages with patients regarding cost implications of treatment options.	
GUIDANCE	**EVIDENCE**
Cost can play a major treatment adherence; the practice understands this and talks to patients about treatment costs (e.g., adds a financial question to the clinical intake screening [do you have trouble affording the care or prescriptions prescribed? Y/N], directs patients to resources such as copay and prescription assistance programs; the clinician asks about prescription drug coverage, tells patients which services are critical and should not be skipped, recommends less expensive options, if appropriate).	**Documented process** ***AND*** **Evidence of implementation**  ***Documented process only***

Table of Contents

 = Evidence shareable across practice sites

Care Coordination and Care Transitions (CC)

CC Competency C: Coordinating Care With Health Care Facilities.

CC 21 (*Maximum* 3 Credits) External Electronic Exchange of Information: Demonstrates electronic exchange of information with external entities, agencies and registries (may select one or more):

A. Regional health information organization or other health information exchange source that

B. Immunization registries or immunization information systems. (1 Credit)

C. Summary of care record to another provider or care facility for care transitions. (1 Credit)

GUIDANCE	EVIDENCE
The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this electronic exchange by: **A.** Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. **B.** Submitting electronic data to immunization registries, to share immunization services provided to patients. **C.** Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each criterion, for up to three credits. Each option is part of CC 21, but is listed separately in Q-PASS for scoring purposes.	**Evidence of implementation**

Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality,

QI 03 (Core) Appointment Availability Assessment: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	
GUIDANCE	**EVIDENCE**
Patients who cannot get a timely appointment with their primary care provider may seek out-of-network care, facing potentially higher costs and treatment from a provider who does not know their medical history. The practice consistently reviews the availability of major appointment types (e.g., urgent care, new patient, routine exams, follow-up) to ensure that it meets the needs and preferences of its patients, and adjusts appointment availability, if necessary (e.g., seasonal changes, shifts in patient needs, practice resources). A common approach to measuring appointment availability against standards is to determine the third next available appointment for each appointment type.	**Documented process** ***AND***

QI 04 (Core) Patient Experience Feedback: *continued*	
GUIDANCE	**EVIDENCE**
urgent care, advice, assistance and support	

QI 06 (1 Credit) Validated Patient Experience Survey Use: The practice uses a standardized, validated patient experience survey tool with benchmarking data available.	
GUIDANCE	**EVIDENCE**
The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities. The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices. The practice may use standardized tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) PCMH survey, CAHPS-CG or another standardized survey administered through measurement initiatives providing benchmark analysis external to the practice organization. It may not be a proprietary instrument. The practice must administer the entire approved standardized surve	

QI Competency B: Setting Goals and Acting to Improve.

QI 09 (Core) Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship: A. Measures related to care coordination. B. Measures affecting health care costs.	
GUIDANCE	**EVIDENCE**
The practice has an ongoing quality improvement performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers. Measures selected for improvement may be chosen from the same set of measureBT/F5 12 Tf0.000002 67	

QI Competency B: Setting Goals and Acting to Improve.

QI 11 (Core) Goals and Actions to Improve Patient Experience: Sets goals and acts to improve performance on at least one patient experience measure.

QI Competency C: Reporting Performance.

Competency C: Reporting Performance. The practice is accountable for performance and shares data within the practice, with patients and/or publicly for the measures and patient populations identified in the previous section.

QI 15 (Core) Reporting Performance within the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice provides individual clinician or practice-level reports to clinicians and practice staff. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations (e.g., a larger medical group, individual practice association or health plan).	**Documented process** ***AND*** **Evidence of implementation** 
QI 16 (1 Credit) Reporting Performance Publicly or with Patients: Shares clinician-level or practice-level performance results publicly or with patients for measures it reports.	
GUIDANCE	**EVIDENCE**
The practice shares individual clinician or practice-level reports with patients and the public. Reports reflect the care provided by the care team. Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer. The practice may use data that it produces or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plan.	**Documented process** ***AND*** **Evidence of implementation** 
QI 17 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice has a process for involving patients and their families in its quality improvement efforts or on (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	**Documented process** ***AND*** **Evidence of implementation** 

Table of Contents

 = Evidence shareable across practice sites

QI Competency C: Reporting Performance.

QI 18 (2 Credits) Reporting Performance Measures to Medicare/Medicaid: Reports clinical quality measures to Medicare or to a Medicaid agency.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it reports a minimum number of clinical quality measures to Medicare or to a state Medicaid agency: At least one immunization measure. One preventive care measure (not including immunizations). One chronic or acute care clinical measure. One behavioral health measure.	**Evidence of submission**

QI 19 (*Maximum* 2 Credits) Value-Based Contract Agreements: Is engaged in a value-based agreement.

A. Practice engages in upside risk contract (1 Credit).

B. Practice engages in two-