

PCMH Standards and Guidelines

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, without the written permission of NCQA.

© 2025 by the National Committee for Quality Assurance (NCQA)
1100 13th Street NW, Third Floor
Washington, DC 20005

All rights reserved.

NCQA Customer Support: 888-275-7585

Table of Contents

<u>Team-Based Care and Practice Organization (TC)</u>	35
<u>Competency A</u>	35
<u>TC 01 PCMH Transformation Leads</u>	35
<u>TC 02 Structure and Staff Responsibilities</u>	35
<i>TC 03 Retired in 2026</i>	
<u>TC 04 Patient/Family/Caregiver Involvement in Governance</u>	36
<u>TC 05 Certified EHR System</u>	36
<u>Competency B</u>	37
<u>TC 06 Individual Patient Care Meetings/Communication</u>	37
<u>TC 07 Staff Involvement in Quality Improvement</u>	37
<u>TC 08 Behavioral Health Care Manager</u>	38
<u>Competency C</u>	39
<i>TC 09 Retired in 2026</i>	
<u>TC 10 Patient Consent - NEW</u>	39
<u>Knowing and Managing Your Patients (KM)</u>	40
<u>Competency A</u>	40
<u>KM 01 Problem Lists</u>	40
<u>KM 02 Comprehensive Health Assessment</u>	41
<u>KM 03 Depression Screening</u>	43
<u>KM 04 Behavioral Health Screenings</u>	44
<u>KM 05 Oral Health Assessment and Services</u>	47
<u>KM 06 Predominant Conditions and Concerns</u>	47
<u>KM 07 Social Determinants of Health</u>	48
<i>KM 08 Retired in 2026</i>	
<u>Competency B</u>	49
<u>KM 09 Diversity</u>	49
<u>KM 10 Language</u>	49
<u>KM 11 Population Needs</u>	50
<u>Competency C</u>	51
<u>KM 12 Proactive Reminders</u>	51
<u>KM 13 Excellence in Performance</u>	51
<u>Competency D</u>	52
<u>KM 14 Medication Reconciliation</u>	52
<u>KM 15 Medication Lists</u>	52
<u>KM 16 New Prescription Education</u>	53
<u>KM 17 Medication Responses and Barriers</u>	53
<i>KM 18 Retired in 2026</i>	
<u>KM 19 Prescription Claims Data</u>	53
<u>Competency E</u>	54
<u>KM 20 Clinical Decision Support</u>	54
<u>Competency F</u>	56
<u>KM 21 Community Resource Needs</u>	56
<u>KM 22 Access to Educational Resources</u>	56
<u>KM 23 Oral Health Education</u>	57
<u>KM 24 Shared Decision-Making Aids</u>	57
<i>KM 25 Retired in 2026</i>	
<u>KM 26 Community Resource List</u>	58
<u>KM 27 Community Resource Assessment</u>	58
<i>KM 28 Retired in 2026</i>	
<u>Competency G</u>	59
<u>KM 29 Opioid Treatment Agreement</u>	59
<u>Competency H</u>	60
<u>KM 30 Prescribing Patterns - NEW</u>	60
<u>KM 31 Interpreter Services - NEW</u>	60




Table of Contents

KM 32 Virtual Care Training - NEW	61
Patient-Centered Access and Continuity (AC)	62
Competency A	62
AC 01 Access Needs and Preferences	62
AC 02 Same-Day Appointments	63
AC 03 Appointments Outside Business Hours	63
AC 04 Timely Clinical Advice by Telephone	64
AC 05 Clinical Advice Documentation	65
AC 06 Alternative Appointments	65
AC 07 Electronic Patient Requests	66
AC 08 Two-Way Electronic Communication	66
AC 09 Equity of Access	67
Competency B	68
AC 10 Personal Clinician Selection	68
AC 11 Patient Visits with Clinician/Team	68
AC 12 Continuity of Medical Record Information	69
AC 13 Panel Size Review and Management	69
AC 14 External Panel Review and Reconciliation	69
Competency C	70
AC 15 Appropriate Modality of Care - NEW	70
AC 16 Information for Appeals - NEW	70
AC 17 Services Covered by Insurance - NEW	71
Care Management and Support (CM)	72
Competency A	72
CM 01 Identifying Patients for Care Management	72
CM 02 Monitoring Patients for Care Management	73
CM 03 Comprehensive Risk-Stratification Process	73
Competency B	74
CM 04 Person-Centered Care Plans	74
CM 05 Written Care Plans	75
CM 06 Patient Preferences and Goals	75
CM 07 Patient Barriers to Goals	76
CM 08 Self-Management Plans	76
CM 09 Care Plan Integration	76
CM 10 Person-Centered Outcomes Approach	77
CM 11 Person-Centered Outcomes Approach: Monitoring and Follow-Up	78
Care Coordination and Care Transitions (CC)	79
Competency A	79
CC 01 Lab and Imaging Test Management	79
CC 02 Newborn Screenings	80
CC 03 Appropriate Use for Labs and Imaging	80
Competency B	81
CC 04 Referral Management	81
CC 05 Appropriate Referrals	83
CC 06 Commonly Used Specialists Identification	83
CC 07 Performance Information for Specialist Referrals	83
CC 08 Specialist Referral Expectations	84
CC 09 Behavioral Health Referral Expectations	84
CC 10 Behavioral Health Integration	85
CC 11 Referral Monitoring	85
CC 12 Retired in 2026	
CC 13 Connects to Financial Resources	86

Table of Contents

<u>Competency C</u>	87
<u>CC 14 Identifying Unplanned Hospital and ED Visits</u>	87
<u>CC 15 Sharing Clinical Information</u>	87
<u>CC 16 Post-Hospital/ED Visit Follow-Up</u>	88
<u>CC 17 Acute Care After Hours Coordination</u>	88
<u>CC 18 Information Exchange During Hospitalization</u>	88
<u>CC 19 Patient Discharge Summaries</u>	89
<u>CC 20 Care Plan Collaboration for Practice Transitions</u>	89
<u>CC 21 External Electronic Exchange of Information</u>	90
<u>Performance Measurement and Quality Improvement (QI)</u>	92
<u>Competency A</u>	92
<u>QI 01 Clinical Quality Measures</u>	92
<u>QI 02 Resource Stewardship Measures</u>	92
<u>QI 03 Appointment Availability Assessment</u>	93
<u>QI 04 Patient Experience Feedback</u>	93
<u>QI 05 Health Disparities Assessment</u>	95
<u>QI 06 Validated Patient Experience Survey Use</u>	95
<u>QI 07 Vulnerable Patient Feedback</u>	96
<u>Competency B</u>	97
<u>QI 08 Goals and Actions to Improve Clinical Quality Measures</u>	97
<u>QI 09 Goals and Actions to Improve Resource Stewardship Measures</u>	97
<u>QI 10 Goals and Actions to Improve Appointment Availability</u>	98
<u>QI 11 Goals and Actions to Improve Patient Experience</u>	99
<u>QI 12 Improved Performance</u>	99
<u>QI 13 Goals and Actions to Improve Disparities in Care/Services</u>	99
<u>QI 14 Improved Performance for Disparities in Care/Services</u>	99
<u>Competency C</u>	100
<u>QI 15 Reporting Performance Within the Practice</u>	100
<u>QI 16 Reporting Performance Publicly or With Patients</u>	100
<u>QI 17 Patients/Family Caregiver Involvement in Quality Improvement</u>	101
<u>QI 18 Retired in 2026</u>	
<u>QI 19 Value-Based Payment Arrangements</u>	101
<u>Competency D</u>	102
<u>QI 20 Assessment of Clinician and Care Team Experience -NEW</u>	102
<u>QI 21 Goals and Actions to Improve Clinician and Care Team Experiences -NEW</u>	102

Symbol Legend

PCMH PUBLICATION SYMBOL LEGEND		
Symbol	Meaning	Description
	Site-Specific	For organizations with multiple sites, criteria require evidence to be demonstrated for each site.
	Shared	For organizations with multiple sites, criteria may be demonstrated once and credit for the component shared across all sites. <i>Note: If an organization shares criteria within or between programs, it is attesting that all practices pursuing or holding Recognition status follow the same policies and procedures, use the same systems and uniformly conduct the activities at all practices and specialties.</i>
NYS	New York State PCMH Required Criterion	The “NYS” icon indicates 1 of the 11 elective criteria that must be completed to achieve NYS PCMH Recognition. Refer to Appendix 7 for information.
	Cross-Program Shared Credit Option	Criteria may be shared between programs for organizations seeking PCMH Recognition: <ul style="list-style-type: none"> • With an existing Recognition status (e.g., PCSP) or • With other Recognition programs concurrently. <p>Specific shared-credit alignment is noted next to the symbol.</p> <p><i>Note: If an organization shares criteria within or between programs, it is attesting that all practices pursuing or holding Recognition status follow the same policies and procedures, use the same systems and uniformly conduct the activities at all practices and specialties.</i></p>

Team-Based Care and Practice Organization (TC)

The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.

Competency A: The Practice’s Organization. The practice commits to transforming into a sustainable, patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice’s organizational structure.

TC 01 (Core) PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.

GUIDANCE	EVIDENCE
<p>The practice identifies the clinician lead <i>and</i> the transformation manager (the person leading the PCMH transformation). This may be the same person.</p> <p>Identification of the lead/manager includes:</p> <ul style="list-style-type: none"> • Name. • Credentials. • Roles/responsibilities. <p>Practice transformation is successful when there is support from a clinician lead. The lead sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinical and operational support and resources to implement the PCMH model.</p>	<ul style="list-style-type: none"> • Details about the clinician lead <p>AND</p> <ul style="list-style-type: none"> • Details about the PCMH manager



TC 02 (Core) Structure and Staff Responsibilities: Defines the practice’s organizational structure and staff responsibilities/skills to support key practice functions.

GUIDANCE	EVIDENCE
<p>The practice provides an overview of practice staff roles and an outline of duties staff will execute as part of the medical home, and explains how it will support and train staff to complete these duties.</p> <p>Structured tasks and stated staff responsibilities enable a practice to ensure that staff provide efficient medical care and are trained in the skills necessary to support the functions of the medical home.</p>	<ul style="list-style-type: none"> • Staff structure overview <p>AND</p> <ul style="list-style-type: none"> • Description of staff roles, skills and responsibilities



TC 03 (1 Credit) RETIRED IN 2026

[Table of Contents](#)
[Symbol Legend](#)

TC Competency A: The Practice's Organization



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
<p>The practice either:</p> <ul style="list-style-type: none"> Creates a role for patients/families/caregivers in the practice's governance structure or on its Board of Directors, or Organizes a Patient and Family Advisory Council (PFAC) (stakeholder committee). <p>The practice specifies:</p> <ul style="list-style-type: none"> How patients/families/caregivers are selected for participation. The patient/family/caregiver's role. Frequency of meetings. <p>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.</p>	<ul style="list-style-type: none"> Documented process <p>AND</p> <ul style="list-style-type: none"> Evidence of implementation




NYS

TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.

GUIDANCE	EVIDENCE
<p>The practice enters the names of the certified electronic health systems it is actively using.</p> <p>Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently.</p> <p>Reference</p> <p>https://chpl.healthit.gov/#/search</p>	<ul style="list-style-type: none"> CEHRT name <p> PCSP TC 05</p> <p></p>

[Table of Contents](#)
[Symbol Legend](#)


TC Competency B: Team Communication

TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.	
GUIDANCE	EVIDENCE
<p>The practice identifies the behavioral healthcare manager and provides their qualifications. The care manager has the training to support behavioral health needs in the primary care office and coordinate referrals to specialty behavioral health services outside the practice. The behavioral healthcare manager may conduct duties through telehealth.</p> <p>The practice demonstrates that it is working to provide meaningful behavioral health services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.</p> <p>Note: <i>The care manager is not required to be a clinician, but must have the training, as defined by the practice, to support behavioral health needs in the primary care setting and to coordinate behavioral health services.</i></p>	<ul style="list-style-type: none"> • Identified behavioral healthcare manager <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)

TC Competency C: Medical Home Responsibilities

Competency C: Medical Home Responsibilities. The medical home is prepared to obtain patient consent if it provides virtual care.

TC 09 (Core) RETIRED IN 2026	
TC 10 (1 Credit) Patient Consent: The organization requests patient consent to treatment through virtual modalities.	
GUIDANCE	EVIDENCE
<p>The organization’s process for requesting patient consent to virtual care includes documenting when consent is requested and if it is received through the patient’s health plan, if applicable.</p> <p>Before a virtual visit or encounter, the organization confirms:</p> <ul style="list-style-type: none"> • That the patient is in a location conducive to receiving virtual care. • The patient’s geographical location aligns with the treating clinician’s licensure requirements. 	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>


[Table of Contents](#)
[Symbol Legend](#)

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.

Competency A: Collecting Patient Information. The practice routinely collects comprehensive patient data, and uses the data to understand patients’ backgrounds and health risks.

KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.

GUIDANCE	EVIDENCE
<p>Up-to-date means that the patient’s most recent diagnoses—ascertained from previous records, transfer of information from other providers, diagnosis by the clinician or by querying the patient—are added to the problem list.</p> <p>The report shows that the practice updates patients’ problem lists at least annually.</p> <p>The patient’s active problem list or diagnoses should include acute and chronic conditions, behavioral health diagnoses and oral health issues, as well as past diagnoses that are relevant to the patient’s current care. The problem list is a foundation for understanding health risks.</p>	<ul style="list-style-type: none"> • Report <i>OR</i> • KM 06—predominant conditions and health concerns <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)

KM Competency A: Collecting Patient Information

KM 02 (Core) Comprehensive Health Assessment: Comprehensive health assessment includes (all items required):

- A. Medical history of patient and family.
- B. Mental health/substance use history of patient and family.
- C. Family/social/cultural characteristics.
- D. Communication needs.
- E. Behaviors affecting health.
- F. Social functioning.
- G. Social determinants of health.
- H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.)
- I. Advance care planning. (NA for pediatric practices.)

GUIDANCE	EVIDENCE
<p>A comprehensive patient assessment includes an examination of the patient’s social and behavioral influences in addition to a physical health assessment. Comprehensive, current patient data provides a foundation for supporting population needs. The practice reviews patients’ health assessment at least annually.</p> <p>As part of the health assessment, the practice documents the following items in the patient’s medical record.</p> <p><i>Note: If an item does not apply to the patient, note this in the medical record. All patients need all the components addressed in their medical record. Providing components from multiple patients does not meet the intent.</i></p> <p>A. Medical history of patient and family. Patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and “first-degree” relatives (share about 50% of their genes with a specific family member).</p> <p>B. Mental health/substance use history of patient and family. Patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).</p> <p>C. Family/social/cultural characteristics. Social and cultural needs, preferences, strengths and limitations (e.g., family/household structure, support systems, patient/family concerns). Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities).</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation



KM Competency A: Collecting Patient Information

KM 02 Comprehensive Health Assessment <i>continued</i>	
GUIDANCE	EVIDENCE
<p>D. Communication needs. Specific communication requirements due to hearing, vision or cognition issues. <i>Note: This does not address language; refer to KM 10 for language needs.</i></p> <p>E. Behaviors affecting health. Risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status, and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure.</p> <p>F. Social functioning. The patient’s ability to interact with people in everyday social tasks and maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living and social interactions.</p> <p>G. Social determinants of health. Information on social determinants of health: conditions in a patient’s environment where people live, learn, work and play that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental risk factors; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020).</p> <p>H. Developmental screening using a standardized tool. For newborns through 30 months, use of a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months.</p> <p>I. Advance care planning. Patient/family preferences for advance care planning (care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation



[Table of Contents](#)
[Symbol Legend](#)

KM Competency A: Collecting Patient Information

KM 03 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool.	
GUIDANCE	EVIDENCE
<p>The documented process includes the practice’s screening process and approach to follow-up on positive screens. The practice reports the screening rate and identifies the standardized screening tool. Depression screening is completed at least annually.</p> <p>Screening for adults. Screening adults for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up.</p> <p>Screening for adolescents (12–18 years). Screening adolescents for depression with systems in place to ensure accurate diagnosis, effective treatment and follow-up. Screening under age 12 may be conducted as clinically indicated.</p> <p>A standardized tool collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.</p> <p>In caring for the whole person, the medical home recognizes the impact depression can have on a patient’s physical and emotional health. The practice uses a standardized screening tool (e.g., PHQ-9), and acts on the results.</p>	<ul style="list-style-type: none"> • Documented process or • Report <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation



[Table of Contents](#)
[Symbol Legend](#)

KM Competency A: Collecting Patient Information

NYS KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.)


- A. Anxiety.
- B. Alcohol use disorder.
- C. Substance use disorder.
- D. Pediatric behavioral health screening.
- E. Post-traumatic stress disorder.
- F. Attention deficit/hyperactivity disorder.
- G. Postpartum depression.

GUIDANCE	EVIDENCE
<p>Many patients go undiagnosed and untreated for mental health and substance use disorders. The medical home can play a major role in early identification of these conditions. Staff training on the use of standardized tools ensures accurate diagnosis, treatment and follow-up.</p> <p>The documented process includes the practice's screening process and approach to follow-up for positive screens. The practice screens patients at least annually.</p> <p>A standardized tool collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization.</p> <p>The National Institute on Drug Abuse created a chart of Evidence Based Screening Tools for Adults and Adolescents for opioid screening, as well as alcohol and substance use tools.</p> <p>A. The practice conducts assessment for the presence of emotional distress and symptoms of anxiety using any validated tool (e.g., GAD-2, GAD-7). Anxiety disorders (generalized anxiety disorder, panic disorder and social anxiety disorder) are common, often undetected and misdiagnosed, associated with other psychiatric conditions and linked to chronic medical conditions (e.g., heart disease, chronic pain disorders).</p> <p>B. The USPSTF recommends screening adults 18 years or older for alcohol misuse. Practices may use the Alcohol Use Disorders Identification Test (AUDIT), a screening for excessive drinking; the Drug Abuse Screening Test (DAST); Cutting down, Annoyance by criticism, Guilty feeling and Eye-openers Questionnaire (CAGE), CAGE AID for substance abuse; or another validated</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation




[Table of Contents](#)
[Symbol Legend](#)

KM Competency A: Collecting Patient Information

KM 04 Behavioral Health Screenings <i>continued</i>	
GUIDANCE	EVIDENCE
<p>screening tool. The American Academy of Pediatrics' (AAP) Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits, using developmentally appropriate screening tools (e.g., CRAFFT or Alcohol Screening and Brief Intervention for Youth).</p> <p>C. Assessing for substance use can assist the practice in providing needed treatment, referrals and abstinence tools to address the patient's 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).</p> <p>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).</p> <p>E. The practice uses standardized tools to determine if patients have developed post-traumatic stress disorder (PTSD). This condition develops in patients who have experienced a severe and distressing event. The patient subsequently relives the traumatic experience, causing mental distress. Assessments for PTSD support the practice in recognizing the ailment and providing treatment or referrals to appropriate specialists.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)


KM Competency A: Collecting Patient Information

KM 04 Behavioral Health Screenings <i>continued</i>	
GUIDANCE	EVIDENCE
<p>F. Attention deficit/hyperactivity disorder (ADHD) makes it challenging for a person to pay attention and/or control impulsive behaviors. This condition is most commonly diagnosed during childhood, but symptoms can persist through adolescence and adulthood. The Vanderbilt Assessment Scale or the DSM-5 ADHD checklist for adults or children/adolescents are examples of screening tools used to determine if a patient has ADHD. Screening to identify patients with ADHD can lead to earlier diagnosis and treatment and may reduce its impact on patients/families/caregivers.</p> <p>G. The USPSTF recommends screening adults, including pregnant and postpartum women, for depression. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.</p> <p>The USPSTF guidelines suggest screening during and after pregnancy. The AAP’s Bright Futures acknowledges that primary care practices that see both infants and their families have a unique opportunity to integrate postpartum depression screening into the well-childcare schedule. Validated screening tools may include PHQ-2, PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) or other validated screening tools, and screening may be conducted 4–6 weeks postpartum or during the 1-, 2-, 4- or 6-month well-child visits.</p> <p>For a list of screening tools, visit drugabuse.gov, or visit the American Academy of Pediatrics website for a list of pediatric screening tools.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>


[Table of Contents](#)
[Symbol Legend](#)

KM Competency A: Collecting Patient Information

KM 05 (1 Credit) Oral Health Assessment and Services: Assesses oral health needs and provides necessary services during the care visit, based on evidence-based guidelines, or coordinates with oral health partners.

GUIDANCE	EVIDENCE
<p>The practice conducts patient-specific oral health risk assessments at least annually, and keeps a list of oral health partners (e.g., dentists, endodontists, oral surgeons, periodontists) for referrals.</p> <p>Poor oral health can have a significant impact on quality of life and overall health. Primary care practices are uniquely positioned to improve oral health, oral health awareness through education, preventive interventions (e.g., fluoride application, for pediatric patients) and timely referrals.</p> <p>Asking patients for the date of their last dentist visit or providing a list of dentists who are accepting patients, does not meet the intent.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation 


KM 06 (1 Credit) Predominant Conditions and Concerns: Identifies the predominant conditions and health concerns of the patient population.

GUIDANCE	EVIDENCE
<p>The practice analyzes diagnosis codes or problem lists to identify its patients' most prevalent and important conditions and concerns at least annually.</p> <p>Although the general conditions treated in primary care are similar across practices, each medical home has a unique population that influences how the practice organizes work and resources. Knowing its population's top concerns allows the practice to adopt guidelines, focus decision support and outreach efforts, identify specialties to establish clear referral relationships and determine what special services to offer (e.g., group sessions, education, counseling).</p>	<ul style="list-style-type: none"> • List of top priority conditions and concerns 

[Table of Contents](#)
[Symbol Legend](#)

KM Competency A: Collecting Patient Information

KM 07 (2 Credits) Social Determinants of Health: Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.



GUIDANCE	EVIDENCE
<p>After the practice collects information on social determinants of health, it demonstrates the ability to assess data and address identified gaps using community partnerships, self-management resources or other tools to serve the ongoing needs of its population. Assessing and addressing identified gaps occurs is recommended at least annually. Collection of data on social determinants of health (as required in KM 02) is an important step, but the real benefit to the population comes when the practice uses the information to continuously enhance care systems and community connections to systematically address needs.</p>	<ul style="list-style-type: none"> • Report <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

KM 08 (1 Credit) RETIRED IN 2026

[Table of Contents](#)
[Symbol Legend](#)

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 population for at least one driver of health outcome disparities; for example, disability status, veteran status, socioeconomic status, race, ethnicity, sexual orientation.	
GUIDANCE	EVIDENCE
<p>Assessing the diversity of the population can help a practice identify subpopulations with specialized needs or that are subject to systemic barriers that lead to disparities in health outcomes.</p> <p>Although it is voluntary for individuals to report aspects of diversity, the practice must attempt to collect this information directly, at points of patient interaction, for at least one driver at least annually.</p>	<ul style="list-style-type: none"> • Report 
KM 10 (Core) Language: Assesses the language needs of its population.	
GUIDANCE	EVIDENCE
<p>The practice identifies the prevalent language needs of its population. It must collect data directly from all patients and document all languages spoken.</p> <p>All responses (e.g., patient declined to provide language information, primary language is English, patient does not need language services) must be recorded; a blank field does not mean the patient's preferred language is English.</p> <p>Documenting patients' preferred spoken and written language helps the practice identify the language resources required to serve the population effectively (e.g., materials in prevalent languages, translation services, bilingual staff).</p>	<ul style="list-style-type: none"> • Report 


[Table of Contents](#)
[Symbol Legend](#)

KM Competency B: Patient Diversity

NYS

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
<p>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:</p> <ul style="list-style-type: none"> A. Identifies disparities in care and implements actions to reduce the disparity, at least annually. Practices that reduce disparities provide patient-centered care to their vulnerable populations equal to their general population. <p>The practice should use its data to identify any disparity in care/service for a vulnerable group when compared to the general population of the practice. The actions taken should be specific to that vulnerable group to reduce the disparity.</p> <p>Note: Refer to the glossary for the definition of “vulnerable populations.”</p> <ul style="list-style-type: none"> B. Builds a health-literate organization (e.g., applies universal precautions, provides health literacy training for staff, redesigns systems to serve patients at different health literacy levels, utilizes 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. Education occurs at least annually. C. Builds a culturally competent organization that educates staff on how to interact effectively with people of different cultures and be respectful and responsive to the health beliefs and cultural and linguistic needs of patients. Education occurs at least annually. <p>Health literacy resources</p> <ul style="list-style-type: none"> • IOM: Ten Attributes of Health Literate Health Care Organizations • AHRQ: Health Literacy Universal Precautions Toolkit 	<p>A: Evidence of implementation OR A: QI 05 and A: QI 13</p> <p>B: Evidence of implementation C: Evidence of implementation</p> <div style="text-align: center;">  </div>

KM Competency C: Addressing Patient Needs


Competency C: Addressing Patient Needs. The practice proactively addresses the care needs of the patient population to ensure that the population’s needs are met.

KM 12 (Core) Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them or their families/caregivers about needed services (must report at least three categories):

- A. Preventive care services.
- B. Immunizations.
- C. Chronic or acute care services.
- D. Patients not recently seen by the practice.

GUIDANCE	EVIDENCE
<p>The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients, the practice addresses a variety of health care needs using evidence-based guidelines, including missing recommended follow-up visits. The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services.</p>	<ul style="list-style-type: none"> • A, B, D: Report/list, and • A, B, D: Outreach materials • C: Report/list, and • C: Outreach materials <p>OR</p> <ul style="list-style-type: none"> • C: KM 13 <div style="text-align: center; margin-top: 10px;">  </div>



KM 13 (2 Credits) Excellence in Performance: Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.

GUIDANCE	EVIDENCE
<p>At least 75% of eligible clinicians have earned NCQA Heart/Stroke or Diabetes Recognition.</p> <p>Alternatively, the practice demonstrates that it is participating in a program (e.g., MN Community Measures, IHA, performance-based recognition program) that uses a common set of measures to benchmark participant results, has a process to validate measure integrity and publicly reports results. The practice shows (through reports) that clinical performance is above national or regional averages.</p> <p>Note: Recognition must be awarded at the site level. A multi-site organization that earns Recognition at the organization level does not meet the intent.</p>	<ul style="list-style-type: none"> • Heart/Stroke or Diabetes Recognition for at least 75% of eligible clinicians <p>OR</p> <ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 10px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)

KM Competency D: Medication Management


Competency D: Medication Management. The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.

KM 14 (Core) Medication Reconciliation: Reviews and reconciles medications for more than 90% of patients received from care transitions.	
GUIDANCE	EVIDENCE
<p>The practice reviews all prescribed medications a patient is taking, and documents this in the medical record. Conflicts or potential discrepancies in medications are identified and addressed by clinical staff. Medication review and reconciliation occurs at transitions of care, or at least annually.</p> <p>Maintaining an accurate list of a patient's medications reduces the possibility of duplicate medications, medication errors and adverse drug events. Medication reconciliation is an important safety net for patients received from care transitions because they are more likely to be elderly, use multiple pharmacies, have multiple providers and have co-morbid conditions.</p> <p>Medication reconciliation is the process of obtaining and maintaining an accurate list of all medications a patient is taking and addressing potential conflicts, including name, dosage, frequency and drug-drug interactions.</p>	<ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 100px;">  </div>
KM 15 (Core) Medication Lists: Maintains an up-to-date list of medications for more than 90% of patients.	
GUIDANCE	EVIDENCE
<p>The practice collects information from patients about medications they take, and keeps up-to-date lists of patients' medications, at least annually. Medication data should be captured in searchable fields. The list should include the date when it was last updated, prescription and nonprescription medications, over-the-counter medications and herbal and vitamin/mineral/dietary (nutritional) supplements.</p>	<ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 100px;">  </div>


[Table of Contents](#)
[Symbol Legend](#)

KM Competency D: Medication Management

KM 16 (1 Credit) New Prescription Education: Assesses understanding and provides education, as needed, on new prescriptions for more than 50% of patients/families/caregivers.



GUIDANCE	EVIDENCE
<p>The practice uses patient-centered methods, such as open-ended questions (i.e., teach-back collaborative method), to assess patient understanding of new medications prescribed by the primary care provider. Educational materials are designed with regard to patient need (e.g., reading level).</p> <p>According to the CDC, medication for chronic conditions is not taken as prescribed 50% of the time. Barriers to adherence, such as not understanding directions and confusion among multiple medication regimens, lead to poorer health outcomes and compromise patient safety.</p>	<ul style="list-style-type: none"> • Report <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

KM 17 (1 Credit) Medication Responses and Barriers: Assesses and addresses patient response to medications and barriers to adherence for more than 50% of patients, and dates the assessment.

GUIDANCE	EVIDENCE
<p>The practice asks patients if they are having difficulty taking a medication, are experiencing side effects and are taking the medication as prescribed at all relevant visits (e.g., a new diagnosis with medication). If a patient is not taking a medication as prescribed, the practice determines why.</p> <p>Patients cannot get the full benefits of their medications if they do not take them as prescribed.</p>	<ul style="list-style-type: none"> • Report <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

KM 18 (1 Credit) RETIRED IN 2026

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

GUIDANCE	EVIDENCE
<p>The practice systematically obtains prescription claims data or other medication transaction history. This may include systems such as Surescripts e-prescribing network, regional health information exchanges, insurers or prescription benefit management companies.</p> <p>The practice uses prescription claims data to determine whether a patient is adhering to the medication treatment plan.</p>	<ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  <p><i>PCSP KM 14</i></p>  </div>

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: Implements clinical decision support following evidence-based guidelines for care of (must demonstrate at least four):

- A. A mental health condition.
- B. A substance use disorder.
- C. A chronic medical condition.
- D. An acute condition.
- E. A condition related to unhealthy behaviors.
- F. Well-child or adult care.
- G. Overuse/appropriateness issues.

GUIDANCE	EVIDENCE
<p>The practice integrates evidence-based guidelines in its day-to-day operations, frequently referred to as clinical decision support (CDS). CDS is a systematic method of prompting clinicians to consider evidence-based guidelines at the point of care.</p> <p>CDS encompasses a variety of tools, including, but not limited to:</p> <ul style="list-style-type: none"> • Computerized alerts and reminders. • Condition-specific order sets. • Documentation template. • Reference information (e.g., info buttons). <p>Although CDS may relate to clinical quality measures, measures alone do not achieve the broader goals of CDS.</p> <p>A. Mental health. The practice uses evidence-based guidelines to support clinical decisions related to at least one mental health issue (depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer’s) in the care of patients.</p> <p>B. Substance use disorder treatment. The practice uses evidence-based guidelines to support clinical decisions related to at least one substance misuse issue (i.e., illegal drug use, prescription drug addiction, alcoholism) in the care of patients.</p>	<ul style="list-style-type: none"> • Identifies conditions, source of guidelines <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation



[Table of Contents](#)
[Symbol Legend](#)

KM Competency E: Evidence-Based Care



KM 20 (Core) Clinical Decision Support <i>continued</i>	
GUIDANCE	EVIDENCE
<p>C. A chronic medical condition. The practice uses evidence-based guidelines for clinical decision support related to at least one chronic medical condition (arthritis, asthma, cardiovascular disease, COPD, diabetes) in the care of patients.</p> <p>D. An acute condition. The practice uses evidence-based guidelines to support clinical decisions related to at least one acute medical condition (acute back pain, allergic rhinitis, bronchiolitis, influenza, otitis media, pharyngitis, sinusitis, urinary tract infection) in the care of patients.</p> <p>E. A condition related to unhealthy behaviors. The practice uses evidence-based guidelines to support clinical decisions related to at least one unhealthy behavior (obesity, smoking) in the care of patients.</p> <p>F. Well child or adult care. The practice uses evidence-based guidelines to support clinical decisions related to well-child or adult care (age-appropriate screenings, immunizations) in the care of patients.</p> <p>G. Overuse/appropriateness issues. The practice uses evidence-based guidelines to support clinical decisions related to overuse or appropriateness of care issues (use of antibiotics, avoiding unnecessary testing, referrals to multiple specialists) in the care of patients.</p> <p>The American Board of Internal Medicine Foundation’s Choosing Wisely campaign provides information about implementing evidence-based guidelines as clinical decision support.</p>	<ul style="list-style-type: none"> • Identifies conditions, source of guidelines <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation



[Table of Contents](#)
[Symbol Legend](#)




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
<p>The practice identifies needed resources by assessing collected population information (social determinants of health, predominant conditions, ED use and other health concerns) to prioritize community resources (e.g., food banks, support groups) that support the patient population at least annually.</p> <p>The priority needs list should be used to identify the resource list in KM 26.</p>	<ul style="list-style-type: none"> • 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
<p>Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them and teach them better ways to manage their care and help them stay healthy. The practice provides three examples of how it implements these tools for patients.</p> <ul style="list-style-type: none"> • Educational programs and resources may include information about a medical condition or about the patient’s role in managing the 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. For example, a practice gives its hypertensive patients a method of documenting daily blood pressure readings. Patients can track their progress and adjust the treatment or their behavior, if necessary. 	<ul style="list-style-type: none"> • Evidence of implementation 

[Table of Contents](#)
[Symbol Legend](#)

KM Competency F: Connecting With Community Resources


KM 22 (1 Credit) Access to Educational Resources <i>continued</i>	
GUIDANCE	EVIDENCE
<ul style="list-style-type: none"> The practice provides or shares health education classes, which may include alternative approaches such as peer-led discussion groups or shared medical appointments (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. 	<ul style="list-style-type: none"> Evidence of implementation 
KM 23 (1 Credit) Oral Health Education: Provides oral health education resources to patients.	
GUIDANCE	EVIDENCE
<p>The practice provides an example of how it encourages healthy oral health practices by providing patients with educational and other resources pertaining to the importance of oral health and hygiene. Oral health education occurs at all relevant visits (e.g., well visits or visits involving oral health).</p> <p>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.</p>	<ul style="list-style-type: none"> Evidence of implementation 
KM 24 (1 Credit) Shared Decision-Making Aids: Adopts shared decision-making aids for preference-sensitive conditions.	
GUIDANCE	EVIDENCE
<p>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.</p> <p>The care team collaborates with patients to help them make informed decisions that align with their preferences and values. Helping patients understand their health condition and engaging them in shared decision-making helps build a trusting relationship.</p> <p>Shared decision-making resources</p> <ul style="list-style-type: none"> International Patient Decision Aid Standards Collaboration (IPDASC) AHRQ's SHARE Approach 	<ul style="list-style-type: none"> Evidence of implementation 

[Table of Contents](#)
[Symbol Legend](#)


KM Competency F: Connecting With Community Resources

KM 25 (1 Credit) RETIRED IN 2026

KM 26 (1 Credit) Community Resource List: Routinely maintains a current community resource list based on the needs identified in KM 21.

GUIDANCE	EVIDENCE
<p>At least annually, the practice maintains a list of resources supported by the community and/or payers by selecting five topics or service areas of importance to the patient population.</p> <p>The list includes services offered outside the practice and its affiliates, and an update/maintenance date to demonstrate that the list is regularly updated.</p> <p>Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to resources provided by the community and/or by payers that support their health and well-being.</p>	<ul style="list-style-type: none"> • List of resources 

KM 27 (1 Credit) Community Resource Assessment: Assesses the usefulness of identified community support resources.


GUIDANCE	EVIDENCE
<p>At least annually, the practice assesses the usefulness of resources by requesting and reviewing feedback from patients/families/caregivers about community referrals. Community referrals differ from clinical referrals but may be tracked using the same system.</p> <p>When a practice's patients have unmet social needs, the practice can refer patients to useful community support resources. Meeting the patient's social needs supports self-management and reduces barriers to care.</p>	<ul style="list-style-type: none"> • Evidence of implementation 

KM 28 (2 Credits) RETIRED IN 2026

[Table of Contents](#)
[Symbol Legend](#)

KM Competency G: Additional Patient Collaboration



Competency G: Additional Patient Collaboration. The practice collaborates with patients to support their specific needs.

KM 29 (1 Credit) Opioid Treatment Agreement: Incorporates an opioid treatment agreement into the patient medical record for patients prescribed Schedule II opioid prescriptions.	
GUIDANCE	EVIDENCE
<p>For patients on long-term chronic opioid therapy, a treatment agreement is established between the clinician and patient to support safe prescribing of opioids. Patients prescribed a Schedule II opioid require a treatment agreement signed by both parties that, at a minimum:</p> <ul style="list-style-type: none"> Outlines joint expectations and responsibilities of clinician and patient. Includes the patient’s pain management plan, to prevent development of an opioid dependency. Is included in the patient’s medical record. <p>Patients with a signed opioid treatment agreement have shown improved guideline adherence and reduced addiction risk.</p> <p>This criterion aligns with Quality Payment Program final policies for CY 2019 to address efforts to improve treatment of opioid use disorders.</p> <p>Opioid agreement resources</p> <ul style="list-style-type: none"> National Institute on Drug Abuse Opioid Treatment Contract in Hegmann, K.T., et al., Editors. <i>Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers</i>. Reed Group, 2017. Rhode Island Department of Health 	<ul style="list-style-type: none"> Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)



KM Competency H: Advanced Activities

Competency H: Advanced Activities. The medical home has adopted advanced criteria to the PCMH beginning in 2026.

KM 30 (2 Credits): Prescribing Patterns: The organization tracks medication prescribing practices and performs analysis on prescribing patterns.	
GUIDANCE	EVIDENCE
<p>The organization has a process for tracking prescribed medications. The organization tracks practitioner prescriptions of high-risk medications such as antibiotics, opioids, steroids and benzodiazepines. The organization tracks and analyzes trends or patterns in the practitioner’s prescribing history.</p> <p>The organization provides evidence that it tracks medication prescribing practices and provides reports on its analysis or prescribing patterns.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 10px;">  </div>
KM 31 (1 Credit) Interpreter Services: The organization uses competent interpreter or bilingual services to communicate with individuals in a language other than English.	
GUIDANCE	EVIDENCE
<p>The organization has a process for providing care in a patient’s preferred language, based on language data collected. The organization provides competent interpreter or bilingual services for languages other than English spoken by 5% of the population, or by 1,000 individuals, whichever is less. A “competent interpreter” understands and speaks with enough fluency in both the source and target languages to convey intended meaning. The organization provides reports or materials as evidence that it uses competent interpreter or bilingual services to communicate with individuals who need language assistance.</p> <p>The organization may provide interpreter services directly through professional interpreters or bilingual staff, or through contracts with language service clinicians, including electronic media (e.g., telephone language lines, video links, mobile applications) and other remote systems.</p> <p>“Bilingual staff” speak both English and the patient’s language and can perform their responsibilities in either language.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Reports or • Materials <div style="text-align: center; margin-top: 10px;">  </div>




[Table of Contents](#)
[Symbol Legend](#)

KM Competency H: Advanced Activities

KM 31 Interpreter Services <i>continued</i>	
GUIDANCE	EVIDENCE
<ul style="list-style-type: none"> • If the organization uses staff interpreters or bilingual staff, its process for assessing translators includes assessing their proficiency in the source and target languages, and interpretation training for staff who provide interpreter services. • If the organization uses external interpreter services, its process for procuring interpreters includes assessing their competence. 	
KM 32 (1 Credit) Virtual Care Training: The organization provides staff training on relevant clinical and nonclinical topics.	
GUIDANCE	EVIDENCE
<p>The organization defines on-boarding requirements for the care team, clinical operations staff and practitioners who are new to virtual care, and for annual training of existing staff.</p> <p>The organization determines:</p> <ul style="list-style-type: none"> • The clinical and nonclinical topics required for training, including how training varies across clinician types. • The organization reviews that practitioners have been trained in their domain/ specialty of care (e.g., primary care practitioners have received appropriate training in primary care). <p>At a minimum, training includes:</p> <ul style="list-style-type: none"> – How to deliver care through virtual modalities. – “Webside manner”: Considerations for synchronous video professional display on camera, lighting, background and interpersonal communication skills for building trust in a virtual environment.¹ <ul style="list-style-type: none"> • Training type and frequency. • Staff who require training. <p>The organization provides evidence of at least one training material used, and reviews reports on the percentage of staff who completed training.</p> <p>¹To succeed with telehealth, know your “webside manner” American Medical Association (ama-assn.org)</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report <p>AND</p> <ul style="list-style-type: none"> • Materials
	


[Table of Contents](#)
[Symbol Legend](#)

AC Competency A: Patient Access to the Practice


AC 03 (Core) Appointments Outside Business Hours <i>continued</i>	
GUIDANCE	EVIDENCE
<p>Providing extended access does not include:</p> <ul style="list-style-type: none"> • Offering appointments when the practice would otherwise be closed for lunch. • Offering daytime appointments when the practice would otherwise close early (e.g., a Friday afternoon or holiday). • Utilizing an ED. • Utilizing an urgent care facility that is unaffiliated with the practice. <p>Note: <i>Appointments need to be scheduled for both routine and urgent needs, and patients need to be notified of the availability of appointments outside business hours.</i></p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>
AC 04 (Core) Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.	
GUIDANCE	EVIDENCE
<p>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. Patient inquiries regarding prescription refills or appointment requests are not considered clinical advice.</p> <p>Providing advice outside of appointments helps reduce unnecessary roomed visits and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient.</p> <p>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.</p> <p>NCQA reviews a report summarizing the practice’s expected response times and how it monitors its performance against standards for timely response, both during and after office hours. The practice must present data on at least 7 days of such calls.</p> <p>Note: <i>Organizations that utilize a central call center for clinical advice may aggregate and submit data as shared evidence. If each site is responsible for its phone calls, the organization submits data at the site level.</i></p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 20px;">  <p style="margin-top: 5px;">PCSP AC 02 <i>Documented process only</i></p>  </div>

AC Competency A: Patient Access to the Practice

AC 05 (Core) Clinical Advice Documentation: Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient’s medical record.

GUIDANCE	EVIDENCE
<p>The practice documents all clinical advice in the patient record, whether it is provided by phone, during a telehealth visit or by secure electronic message. Evidence includes two examples of documenting clinical advice (one during office hours and one after normal business hours as defined in AC 03).</p> <p>If a practice uses a system of documentation outside the medical record for after-hours clinical advice or provides after-hours care without access to the patient’s record, it reconciles this information with the medical record on the next business day.</p> <p>The reconciliation evaluates if clinical advice or care provided after hours conflicts with advice and care needs previously documented in the medical record and addresses any identified conflicts.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="display: flex; align-items: center;">  <div> <p>PCSP AC 04 <i>Documented process only</i></p> </div> </div>


AC 06 (1 Credit) Alternative Appointments: Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.

GUIDANCE	EVIDENCE
<p>The practice uses a mode of real-time communication (e.g., a combination of telephone, video chat, secure instant messaging) in place of a traditional in-person office visit with a clinician. The practice provides a report of the number and types of visits in a specified time period.</p> <p>The following types of visits do not meet the requirement:</p> <ul style="list-style-type: none"> • Unscheduled alternative clinical encounters during office hours, including clinical advice by telephone and secure electronic communication (e.g., electronic message, website). • Appointments with an alternative type of clinician (e.g., diabetic counselor). • Appointments restricted to a subset of patients (e.g., only patients identified for care management or patients with specific conditions). • Group visits and home visits. 	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report <div style="display: flex; align-items: center;">  <div> <p><i>Documented process only</i></p> </div> </div>

[Table of Contents](#)
[Symbol Legend](#)


AC Competency A: Patient Access to the Practice

AC 07 (1 Credit) Electronic Patient Requests: Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.

GUIDANCE	EVIDENCE
<p>Patients can use a secure electronic system (e.g., website, patient portal, email) to request appointments, prescription refills, referrals and test results. The practice must demonstrate at least two functionalities or provide patients with guidelines for at least two types of these requests that can be made electronically.</p> <p>Electronic patient requests are another means to enhance patients' access to services that meet their needs and preferences.</p>	<ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

NYS


AC 08 (1 Credit) Two-Way Electronic Communication: Has a secure electronic system for two-way communication to provide timely clinical advice.

GUIDANCE	EVIDENCE
<p>The practice has a secure, interactive electronic system (e.g., website, patient portal, secure email system) that allows two-way communication between the practice and patients/families/caregivers, as applicable for the patient. The practice can send messages to and receive messages from patients.</p> <p>NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response, both during and after office hours.</p> <p>The practice must present data on at least 7 days of such activity. The report may be system generated. The practice defines the time frame for a response and monitors the timeliness of responses against the time frame.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)

AC Competency A: Patient Access to the Practice



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
<p>Knowing whether groups of patients experience differences in access to health care can help practices focus efforts to address the disparity. At least annually, the practice evaluates whether identified health disparities demonstrate differences in access to care.</p> <p>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.</p> <p>Healthy People 2020 defines health disparity as “a 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 exclusion.”</p>	<ul style="list-style-type: none"> • Evidence of implementation 

[Table of Contents](#)
[Symbol Legend](#)

AC Competency B: Empanelment and Access to the Medical Record

Competency B: Empanelment and Access to the Medical Record. Practices support continuity through empanelment and systematic access to the patient’s medical record.

AC 10 (Core) Personal Clinician Selection: Helps patients/families/caregivers select or change a personal clinician.	
GUIDANCE	EVIDENCE
<p>Giving patients/families/caregivers a choice of clinician emphasizes the importance of the ongoing patient-clinician relationship.</p> <p>The practice documents patients’ choice of clinician, gives patients/families/caregivers information about the importance of having a personal clinician and care team responsible for coordinating care and assists in the selection process. The practice may document a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a practice team. Single-clinician sites automatically meet this criterion.</p>	<ul style="list-style-type: none"> • Documented process 
AC 11 (Core) Patient Visits With Clinician/Team: Sets goals and monitors the percentage of patient visits with the selected clinician or team.	
GUIDANCE	EVIDENCE
<p>The practice establishes a goal for the proportion of visits a patient should have with the primary care provider and care team. The goal should acknowledge that meeting patient preferences for timely appointments will sometimes be at odds with the ability to see their selected clinician. The practice reviews this criterion at least annually.</p> <p>Empanelment is assigning individual patients to individual primary care providers and care teams, with sensitivity to patient and family preferences. It is the basis for population health management and the key to continuity of care: Patients can build a better relationship with a clinician or team they see regularly.</p>	<ul style="list-style-type: none"> • Report 

[Table of Contents](#)
[Symbol Legend](#)

AC Competency B: Empanelment and Access to the Medical Record

NYS

AC 12 (2 Credits) Continuity of Medical Record Information: Provides continuity of medical record information for care and advice when the office is closed.

GUIDANCE	EVIDENCE
<p>The practice makes patient clinical information available to on-call staff, external facilities and clinicians outside the practice, as appropriate, when the office is closed or when appointments are conducted using telehealth technology.</p> <p>Access to medical records may include direct access to an EHR, or arranging a telephone consultation with a clinician who has access to the medical record.</p>	<ul style="list-style-type: none"> Documented process <div style="display: flex; align-items: center; margin-top: 10px;"> PCSP AC 05 </div> <div style="display: flex; align-items: center; margin-top: 10px;"> </div>

AC 13 (1 Credit) Panel Size Review and Management: Reviews and actively manages panel size.

GUIDANCE	EVIDENCE
<p>The practice has a process to review the number of patients assigned to each clinician and balance the size of each providers' patient panel at least annually.</p> <p>Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and clinician workload because supply is balanced with patient demand.</p> <p>The American Academy of Family Physicians provides a tool for practices to use when considering and managing panel size.</p>	<ul style="list-style-type: none"> Documented process <p>AND</p> <ul style="list-style-type: none"> Report <div style="display: flex; align-items: center; margin-top: 10px;"> Documented process only </div>



AC 14 (1 Credit) External Panel Review and Reconciliation: Reviews and reconciles panels based on health plan or other outside patient assignments.

GUIDANCE	EVIDENCE
<p>The practice receives reports from outside entities, such as health plans, ACOs and Medicaid agencies, on patients that are attributed to each clinician. The practice has a process for reviewing reports, and for informing the entities of patients known or not known to be under the care of clinicians at least annually.</p> <p>Reconciling panels with health plans and other entities improves accountability, continuity and access.</p>	<ul style="list-style-type: none"> Documented process <p>AND</p> <ul style="list-style-type: none"> Evidence of implementation <div style="display: flex; align-items: center; margin-top: 10px;"> Documented process only </div>

[Table of Contents](#)
[Symbol Legend](#)

AC Competency C: Advanced Activities


Competency C: Advanced Activities. The medical home has adopted advanced criteria beginning in 2026.

AC 15 (1 Credit) Appropriate Modality of Care: The organization has a process for determining that virtual care is appropriate for the patient.	
GUIDANCE	EVIDENCE
<p>Before and during the patient’s virtual visit (as deemed appropriate), the organization has a process to determine if virtual care is appropriate for the patient, with respect to the level of care needed and the organization’s capability.</p> <p>The organization’s assessment process specifies the types of practitioners appropriate for conditions treated through virtual modalities. Patients are treated by practitioners in the same or a similar specialty related to the condition requiring treatment.</p> <p>If the organization determines that virtual modality is inappropriate, including in situations that require escalation to in-person care, it outlines its process for referring patients to care in the appropriate modality.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>
AC 16 (1 Credit) Information for Appeals: The organization provides clinical information in response to appeals of denials based on medical necessity or treatment guidelines.	
GUIDANCE	EVIDENCE
<p>The organization has a process for providing clinical information in response to appeals of denials based on medical necessity or treatment guidelines. Organizations that are participating with insurance will appeal on behalf of the patient. Organizations that are not participating with insurance will provide clinical information to patients in a timely manner to fulfill the appeal. The relevance of clinical information is considered in terms of the criteria used to make the denial decision (i.e., the clinical information provided by the organization is related to the rationale stated in the denial notice).</p> <p>If the organization cannot provide the clinical information relevant to the denial, it documents its attempts to gather the information.</p>	<ul style="list-style-type: none"> • Documented process <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)

AC Competency C: Advanced Activities

AC 17 (2 Credits) Services Covered by Insurance: The organization has a process for informing patients which services are covered by insurance.

GUIDANCE	EVIDENCE
<p>The organization has a process for helping patients determine if services delivered are covered by their insurance, and the amount of copay. The timing and scope of the information is based on the patient’s needs. “Informing patients” may be through referral to additional resources or patient advocacy organizations that specialize in educating patients on insurance benefits.</p> <p>If the organization does not contract with insurance, it outlines its process for informing patients of the cost of the services provided.</p>	<ul style="list-style-type: none"> • Documented process 

[Table of Contents](#)
[Symbol Legend](#)


Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Competency A: Identifying Care Managed Patients. The practice systematically identifies patients who may benefit from care management.


CM 01 (Core) Identifying Patients for Care Management: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (must include at least three):

- A. Behavioral health conditions.
- B. High cost/high utilization.
- C. Poorly controlled or complex conditions.
- D. Social determinants of health.
- E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

GUIDANCE	EVIDENCE
<p>At least annually, the practice defines a protocol for identifying patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A–E. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> A. Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment. B. Patients who experience multiple ER visits, hospital readmissions, high total cost of care, unusually high numbers of imaging or lab tests ordered, unusually high number of prescriptions, high-cost medications and high number of secondary specialist referrals. C. Patients with poorly controlled or complex conditions such as continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions. D. Availability of resources to meet daily needs, such as food and transportation; access to educational, economic and job opportunities; public safety; social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). E. Direct identification of patients who might need care management, such as referrals by health plans, practice staff, patient, family members or caregivers. 	<ul style="list-style-type: none"> • Protocol for identifying patients for care management <p>OR</p> <ul style="list-style-type: none"> • CM 03 


CM Competency A: Identifying Care Managed Patients

CM 02 (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.

GUIDANCE	EVIDENCE
<p>The practice determines its subset of patients for care management, based on the patient population and the practice’s capacity to provide services.</p> <p>At least annually, the practice uses the criteria defined in CM 01 to identify patients. The practice should ensure that criteria are specific enough for any identified patient to have their care managed. The practice must identify at least 30 patients in the numerator. Patients who fit multiple criteria count once in the numerator.</p> <p>With NCQA approval, small practices or satellite sites may share a care management population if fewer than 30 patients meet the criteria defined in CM 01.</p>	<ul style="list-style-type: none"> • Report 

NYS

CM 03 (2 Credits) Comprehensive Risk-Stratification: Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.

GUIDANCE	EVIDENCE
<p>The practice demonstrates that, at least annually, it identifies patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes.</p> <p>The practice identifies and directs resources appropriately based on need.</p> <p>Risk stratification protocol used by the practice must include at least three categories outlined in CM 01.</p> <p>Risk-stratification resources</p> <ul style="list-style-type: none"> • CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model (if the methodology is applied to the entire practice population). • Milliman Advanced Risk Adjusters (MARA) 	<ul style="list-style-type: none"> • Evidence of implementation 

[Table of Contents](#)
[Symbol Legend](#)

CM Competency B: Care Plan Development

CM 05 (Core) Written Care Plans: Provides a written care plan to the patient/family/caregiver for at least 75% of patients identified for care management.

GUIDANCE	EVIDENCE
<p>The practice provides the patient’s written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient’s health literacy and language preferences (the patient version may use different words or formats from the version used by the practice team).</p> <p>At least twice a year, the care plan is printed and given to the patient or made available electronically.</p>	<ul style="list-style-type: none"> • Report <i>OR</i> • Record Review Workbook and • Patient examples <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="font-size: small;"> <p><i>Report or Record Review Workbook</i></p> </div> </div> <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="font-size: small;"> <p><i>Patient examples</i></p> </div> </div>



CM 06 (1 Credit) Patient Preferences and Goals: Documents patient preference and functional/lifestyle goals in at least 75% of individual care plans.

GUIDANCE	EVIDENCE
<p>The practice works with patients/families/ caregivers to incorporate patient preferences and functional lifestyle goals in the care plan at least twice a year. Including patient preferences and goals encourages a collaborative partnership between patient/family/ caregiver and provider, and ensures that patients are active participants in their care.</p> <p>Functional/lifestyle goals can be individually meaningful activities that a person wants to be able to perform but that may be at risk due to a health condition or treatment plan. Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.</p>	<ul style="list-style-type: none"> • Report <i>OR</i> • Record Review Workbook and • Patient examples <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="font-size: small;"> <p><i>Report and Record Review Workbook</i></p> </div> </div> <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="font-size: small;"> <p><i>Patient examples</i></p> </div> </div>



[Table of Contents](#)
[Symbol Legend](#)

CM Competency B: Care Plan Development


CM 07 (1 Credit) Patient Barriers to Goals: Identifies and discusses potential barriers to meeting goals in at least 75% of individual care plans.

GUIDANCE	EVIDENCE
<p>Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may be physical, emotional or social.</p> <p>At least twice a year, the practice works with patients/families/ caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/lifestyle goals.</p>	<ul style="list-style-type: none"> • Report OR • Record Review Workbook and • Patient examples <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;">  <i>Report and Record Review Workbook</i> </div> <div style="text-align: center;">  <i>Patient examples</i> </div> </div>

CM 08 (1 Credit) Self-Management Plans: Includes a self-management plan in at least 75% of individual care plans.

GUIDANCE	EVIDENCE
<p>The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition, at least twice a year. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan.</p> <p>Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers to meeting care-plan goals.</p>	<ul style="list-style-type: none"> • Report OR • Record Review Workbook and • Patient examples <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;">  <i>Report and Record Review Workbook</i> </div> <div style="text-align: center;">  <i>Patient examples</i> </div> </div>



NYS CM 09 (1 Credit) Care Plan Integration: Care plan is integrated and accessible across settings of care.

GUIDANCE	EVIDENCE
<p>Sharing the care plan supports its implementation across all settings that address the patient's care needs.</p> <p>The practice makes the care plan accessible across external care settings. The care plan is integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.</p>	<ul style="list-style-type: none"> • Documented process AND • Evidence of implementation <div style="text-align: center; margin-top: 10px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)



CM Competency B: Care Plan Development

CM 11 (1 Credit) Person-Centered Outcomes (PCO) Approach: Monitoring and Follow-Up.
 Follow up on care plan goal within 180 days for at least 75% of individual care plans.

GUIDANCE	EVIDENCE
<p>The PCO approach aligns patients' personal goals with their health outcomes. At least twice a year, the clinician uses either a patient-reported outcome measure (PROM) or goal attainment scaling to document and measure a health outcome goal and document what matters most to the patient (e.g., attend a graduation, participate in a 5K walk), then monitor and track progress over time.</p> <p>This criterion, built on CM 10, looks at the percentage of patients with a complex care need whose health outcome goal was documented using either a PROM or goal attainment scaling, and who had at least one follow-up within 180 days to monitor and review progress toward reaching the goal and to address any barriers to success. There must be documentation of monitoring and follow-up for at least 75% of individual care plans.</p>	<ul style="list-style-type: none"> • Report OR • Record Review Workbook and • Patient examples <p>Note: <i>This criterion cannot be met without meeting CM 10.</i></p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="text-align: center;">  </div> <div style="text-align: left;"> <p><i>Report and Record Review Workbook</i></p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="text-align: center;">  </div> <div style="text-align: left;"> <p><i>Patient examples</i></p> </div> </div>

[Table of Contents](#)
[Symbol Legend](#)

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.	
GUIDANCE	EVIDENCE
<p>The practice follows up with the hospital or state health department if it does not receive screening results.</p> <p>Most states mandate that birthing facilities perform a blood-spot test to screen for congenital conditions (based on recommendations by the American Academy of Pediatrics and the American College of Medical Genetics) and a hearing screening on all newborns. Early detection and treatment of congenital disorders can enhance health outcomes for newborns with positive (abnormal) screening results.</p> <p>Practices that do not see newborn patients are not eligible for this elective criterion.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>
CC 03 (2 Credits) Appropriate Use for Labs and Imaging: Uses clinical protocols to determine when imaging and lab tests are necessary.	
GUIDANCE	EVIDENCE
<p>The practice establishes clinical protocols based on evidence-based guidelines to determine when imaging and lab tests are necessary. The practice may implement clinical decision supports to ensure that protocols are used (e.g., embedded in the order entry system).</p> <p>Inappropriate use of imaging or lab tests leads to unnecessary costs and risks, and does not enhance patient outcomes.</p>	<ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)



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. Tracking referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports.**




GUIDANCE	EVIDENCE
<p>The practice uses the patient’s medical health history and clinical protocols to determine when a referral is necessary. 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 services, as well as frustration for providers.</p> <p>Referrals may be tracked by the practice using a log or electronic system, as determined by the clinician to be important to a patient’s treatment, or as indicated by practice guidelines (e.g., referral to a surgeon for examination of a potentially malignant tumor; referral to a mental health specialist, for a patient with depression; referral to a pediatric cardiologist, for an infant with a ventricular septal defect).</p> <p>The organization confirms that referrals are local to the patient’s community of residence, and whether the referral is in the patient’s practitioner network.</p> <p>A. The referring clinician provides a reason for the referral, which may be stated as the clinical question to be answered by the specialist. The referring clinician indicates the type of referral, which may be a consultation or single visit; a request for shared- or co-management of the patient for an indefinite or a limited time, such as for treatment of a specific condition; or a request for temporary or long-term principal care (a transfer). The referring clinician clarifies the urgency of the referral and specifies the reasons for an urgent appointment.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: right; margin-top: 20px;">  PCSP CC 03 <i>Documented process only</i> </div> <div style="text-align: right; margin-top: 10px;">  </div>

CC Competency B: Referrals to Specialists

CC 04 (Core) Referral Management <i>continued</i>	
GUIDANCE	EVIDENCE
<p>B. Referrals include relevant clinical information such as:</p> <ul style="list-style-type: none"> • Current medications. • Diagnoses, including mental health, allergies, medical and family history, substance abuse and behaviors affecting health. • Clinical findings and current treatment. • Follow-up communication or information. <p>Including the referring primary care clinician’s 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.</p> <p>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 specialist’s office and documents its effort to retrieve the report in a log or an electronic system. The expectation is that the specialist/ancillary clinician return visit documentation so the loop can be closed.</p>	 <p>PCSP CC 03 <i>Documented process only</i></p> 

[Table of Contents](#)
[Symbol Legend](#)

CC Competency B: Referrals to Specialists


CC 05 (2 Credits) Appropriate Referrals: Uses clinical protocols to determine when a referral to a specialist is necessary.	
GUIDANCE	EVIDENCE
<p>The practice uses the patient’s medical health history, clinical protocols or decision-support tools to determine if a patient needs to be seen by a specialist, or if care can be addressed or managed by the primary care clinician.</p> <p>Unnecessary referrals can lead to overuse of tests and services, increase patient dissatisfaction and reduce accessibility to specialists when needed.</p>	<ul style="list-style-type: none"> • Evidence of implementation 
CC 06 (1 Credit) Commonly Used Specialists Identification: Identifies the specialists/specialty types frequently used by the practice.	
GUIDANCE	EVIDENCE
<p>At least annually, the practice monitors patient referrals to gain information about the referral specialists and specialty types it uses frequently. Specifying specialty type alone is not sufficient.</p> <p>This information may help identify areas where the practice can adopt guidelines or protocols to manage patient care in the primary care practice and identify trends in the patient population, and can help identify opportunities for improved coordination and patient experience when specialty care is needed.</p>	<ul style="list-style-type: none"> • Evidence of implementation 
CC 07 (2 Credits) Performance Information for Specialist Referrals: Considers available performance information on consultants/specialists when making referrals.	
GUIDANCE	EVIDENCE
<p>It is important for the practice to make informed referrals to clinicians or practices that will provide timely, high-quality care.</p> <p>At least annually, the practice consults available information about the performance of clinicians or practices to which it refers patients.</p> <p>The practice provides information or examples of the available performance data on the consultant/specialist with the practice team. Information gathered in CC 11 may be useful in assessing consultants/specialists.</p>	<ul style="list-style-type: none"> • Data source AND • Examples 

[Table of Contents](#)
[Symbol Legend](#)

CC Competency B: Referrals to Specialists


NYS

CC 08 (1 Credit) Specialist Referral Expectations: Works with nonbehavioral healthcare specialists to whom the practice frequently refers, to set expectations for information sharing and patient care.

GUIDANCE	EVIDENCE
<p>Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).</p> <p>The organization communicates referral expectations to patients, including the contact information of the referring clinician and additional instructions or education, if applicable.</p>	<ul style="list-style-type: none"> • Documented process <p>OR</p> <ul style="list-style-type: none"> • Agreement 



NYS

CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral healthcare providers to whom the practice frequently refers, to set expectations for information sharing and patient care.

GUIDANCE	EVIDENCE
<p>Relationships between primary care practitioners and specialists support consistency of information shared across practices.</p> <p>The practice has established relationships with behavioral healthcare providers through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content). A notification demonstrating legal inability to receive a report confirming that a behavioral health visit occurred meets the content requirement.</p> <p>A practice needs an agreement if it shares the same facility or campus as behavioral healthcare professionals, but has separate systems (basic onsite collaboration) or uses a contracted behavioral telehealth provider. The practice may present existing internal processes if there is partial integration of behavioral healthcare services.</p> <p>The organization communicates referral expectations to patients, including the contact information of the referring clinician and additional instructions or education, if applicable.</p>	<ul style="list-style-type: none"> • Agreement <p>OR</p> <ul style="list-style-type: none"> • Documented process <i>and</i> • Evidence of implementation 

[Table of Contents](#)
[Symbol Legend](#)





CC Competency B: Referrals to Specialists

CC 10 (2 Credits) Behavioral Health Integration: Integrates behavioral healthcare providers into the care delivery system of the practice site.	
GUIDANCE	EVIDENCE
<p>Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting.</p> <p>This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, and have shared accountability and collaborative treatment and workflow strategies. Behavioral health integration using telehealth capabilities is acceptable if the behavioral telehealth provider is integrated into the workflow of the practice.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>
CC 11 (1 Credit) Referral Monitoring: Monitors the timeliness and quality of the referral response.	
GUIDANCE	EVIDENCE
<p>The practice assesses the response received from the consulting/specialty provider and evaluates whether the response was timely and provided appropriate information about the patient's diagnosis and treatment plan.</p> <p>The practice bases its definition of "timely" on patient need. Ongoing assessment and referral monitoring may be helpful in CC 07.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report <div style="text-align: center; margin-top: 20px;">  </div> <p style="text-align: center;"><i>Documented process only</i></p>
CC 12 (1 Credit) RETIRED IN 2026	

[Table of Contents](#)
[Symbol Legend](#)

CC Competency C: Coordinating Care With Health Care Facilities

Competency C: Coordinating Care With Health Care Facilities. The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

CC 14 (Core) Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	
GUIDANCE	EVIDENCE
<p>The practice has a process for monitoring unplanned admissions and ED visits, including their frequency.</p> <p>The practice works with local hospitals, EDs and health plans to proactively identify patients with recent unplanned visits and demonstrates how it systematically receives notifications from facilities with which it has established mechanisms for exchange.</p> <p>Receiving timely notification of patients with unplanned hospital admissions and ED visits allows practices to provide support and coordinate with the hospital or ED.</p> <p>Notification occurs near the time of admission. Relying on notification of discharge alone does not meet the intent.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="display: flex; align-items: center; margin-top: 20px;">  <p>PCSP CC 07 <i>Documented process only</i></p> </div> <div style="display: flex; align-items: center; margin-top: 10px;">  </div>
CC 15 (Core) Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.	
GUIDANCE	EVIDENCE
<p>The practice demonstrates timely sharing of information with admitting hospitals and EDs. The practice provides three examples as evidence of implementation.</p> <p>Shared information supports continuity in patient care across settings.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="display: flex; align-items: center; margin-top: 20px;">  <p>PCSP CC 08 <i>Documented process only</i></p> </div> <div style="display: flex; align-items: center; margin-top: 10px;">  </div>

[Table of Contents](#)
[Symbol Legend](#)

CC Competency C: Coordinating Care With Health Care Facilities

CC 16 (Core) Post-Hospital/ED Visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

GUIDANCE	EVIDENCE
<p>The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice’s policies define the appropriate contact period and systematic documentation of follow-up.</p> <p>Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encourage follow-up care, which may include, but is not limited to, physician counseling, telehealth visits, referrals to community resources and disease or case management or self-management support programs.</p> <p>Note: <i>All discharged patients should be contacted, although not every patient may require a follow-up in the primary care practice.</i></p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="display: flex; align-items: center;"> <div> <p>PCSP CC 09 <i>Documented process Only</i></p> </div> </div> <div style="display: flex; align-items: center;"> <div> <p><i>Documented process only</i></p> </div> </div>

CC 17 (1 Credit) Acute Care After-Hours Coordination: Systematic ability to coordinate with acute care settings after office hours through access to current patient information.


GUIDANCE	EVIDENCE
<p>The practice has a process for coordinating with acute care facilities when a patient is seen after the office is closed.</p> <p>Sharing patient information allows the facility to coordinate patient care based on current health needs and to engage with practice staff.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="display: flex; align-items: center;"> <div> <p>PCSP CC 10 <i>Documented process only</i></p> </div> </div> <div style="display: flex; align-items: center;"> <div> <p><i>Documented process only</i></p> </div> </div>

CC 18 (1 Credit) Information Exchange During Hospitalization: Exchanges patient information with the hospital during a patient’s hospitalization.

GUIDANCE	EVIDENCE
<p>The practice demonstrates that it can send and receive patient information during a patient’s hospitalization.</p> <p>Note: <i>CC 15 assesses the practice’s ability to share information, but the focus of CC 18 is two-way exchange of information.</i></p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="display: flex; align-items: center;"> <div> <p>PCSP CC 11 <i>Documented process only</i></p> </div> </div> <div style="display: flex; align-items: center;"> <div> <p><i>Documented process only</i></p> </div> </div>

CC Competency C: Coordinating Care With Health Care Facilities



CC 20 (1 Credit) Care Plan Collaboration for Practice Transitions *continued*

GUIDANCE	EVIDENCE
<p>Internal medicine practices receiving patients from pediatricians are expected to request/review the transition plan provided by the pediatric practice, or to develop a plan, if one is not provided, to support a smooth and safe transition.</p> <p>Family medicine practices that do not transition patients from pediatric to adult care should still educate patients and families about how the care experience may change as the patient moves into adulthood. Sensitivity to privacy concerns should be incorporated into messaging.</p>	<ul style="list-style-type: none"> • Evidence of implementation 

NYS



CC 21 (Maximum 4 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 enhances the practice’s ability to manage complex patients. (1 Credit)
- 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)
- D. Clinical data exchange with payers. (1 Credit)

GUIDANCE	EVIDENCE
<p>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.</p> <p>Practices can demonstrate this electronic exchange by:</p> <ul style="list-style-type: none"> 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. D. Exchanging patient medical record information with payers. <p>Electronically exchange means that clinical data can be both sent and received electronically.</p>	<ul style="list-style-type: none"> • Evidence of implementation <hr/> <p>NYS PCMH must also:</p> <ul style="list-style-type: none"> • Indicate Qualified Entity <p>A: Practices in New York pursuing NYS PCMH Recognition must demonstrate connection to and exchange of patient information with a Statewide Health Information Network for New York (SHIN-NY) Qualified Entity (NYS regional health information organization).</p> <div style="display: flex; align-items: center; margin-top: 20px;">  <p>PCSP CC 13</p> </div> 

[Table of Contents](#)
[Symbol Legend](#)

CC Competency C: Coordinating Care With Health Care Facilities

CC 21 External Electronic Exchange of Information <i>continued</i>	
GUIDANCE	EVIDENCE
Practices may provide the required evidence for each criterion, for up to 3 credits. Each option is part of CC 21, but is listed separately in Q-PASS for scoring purposes.	  <p>PCSP CC 13</p>

[Table of Contents](#)
[Symbol Legend](#)


Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Competency A: Measuring Performance. The practice measures to understand its current performance and to identify opportunities for improvement.


QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type):

- A. Immunization measures.
- B. Other preventive care measures.
- C. Chronic or acute care clinical measures.
- D. Behavioral health measures.


GUIDANCE	EVIDENCE
<p>Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least:</p> <ul style="list-style-type: none"> • One immunization measure. • One preventive care measure (not including immunizations). • One chronic or acute care clinical measure. • One behavioral health measure. <p>Measures include activities conducted during telehealth visits.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report or • Quality Improvement Worksheet <p><i>Beginning in 2024, practices are to submit eCQM Standardized Measures found on the Measures webpage.</i></p> 

QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource stewardship (must monitor at least one measure of each type):

- A. Measures related to care coordination.
- B. Measures affecting health care costs.

GUIDANCE	EVIDENCE
<p>The practice reports at least two measures related to resource stewardship, including a measure related to health care cost and a measure related to care coordination.</p> <p>When pursuing high-quality, cost-effective outcomes, the practice has a responsibility to consider how it uses resources. Measures include activities conducted during telehealth visits.</p> <p>Note: Reports must represent the practice population (including all relevant subpopulations) and may not be limited to patients of one clinician (of several) or to data from one payer (of several).</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Report or • Quality Improvement Worksheet <p><i>Beginning in 2024, practices are to submit eCQM Standardized Measures found on the Measures webpage.</i></p> 

QI Competency A: Measuring Performance


QI 04 Patient Experience Feedback <i>continued</i>	
GUIDANCE	EVIDENCE
<ul style="list-style-type: none"> • Access to clinical care. May include routine, urgent, after-hours and alternative appointments such as telehealth; ease of getting to the practice, scheduling an appointment or waiting room amenities are not considered access questions. • Communication with the practice, clinicians and staff. May include “feeling respected and listened to” and “able to get answers to questions.” • Coordination of care. May include being informed and up to date on referrals to specialists, changes in medications and lab or imaging results. • Whole-person care/self-management support. May include provision of comprehensive care and self-management support; emphasizing the spectrum of care needs, such as mental health, routine and urgent care, advice, assistance and support for changing health habits and making health care decisions. <p>B. Qualitative methods (e.g., focus groups, individual interviews, patient walkthrough, suggestion box) are another opportunity to obtain feedback from patients. The practice may use a feedback methodology conducive to its patient population, such as virtual (e.g., telephone, videoconference) participation. The practice provides a summarized report of collected feedback.</p> <p>The requirement is not met by:</p> <ul style="list-style-type: none"> • Comments that were collected on surveys to satisfy QI 04, component A, and/or • Feedback collected by Patient and Family Advisory Committees (PFAC) that represent more than one practice and/or do not reflect the entire patient population. 	

[Table of Contents](#)
[Symbol Legend](#)


QI Competency A: Measuring Performance

QI 05 (1 Credit) Health Disparities Assessment: Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section):


- A. Clinical quality.
- B. Patient experience.

GUIDANCE	EVIDENCE
<p>At least annually, the practice stratifies performance data by race and ethnicity or by other indicators of vulnerable groups that reflect the practice’s population demographics (e.g., language needs, education, income, type of insurance [Medicare, Medicaid, commercial], disability, health status).</p> <p>The intent of this criterion is for the practice to work to eliminate disparities in health and delivery of health care for its vulnerable patient populations.</p> <p>Vulnerable populations include those who are socioeconomically disadvantaged, racial and ethnic minorities, the frail elderly, people experiencing homelessness and those who are geographically disadvantaged. When these social factors intersect with health, chronic health conditions may be exacerbated.</p>	<ul style="list-style-type: none"> • Report <p>OR</p> <ul style="list-style-type: none"> • Quality Improvement Worksheet 

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
<p>The practice uses the standardized survey tool to collect patient experience data and inform its quality improvement activities.</p> <p>The intent is for the practice to administer a survey that can be benchmarked externally and compared across practices.</p> <p>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.</p> <p>The practice must administer the entire approved standardized survey (not sections of the survey) to receive credit.</p> <p>CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).</p>	<ul style="list-style-type: none"> • Report 

QI Competency A: Measuring Performance

QI 07 (2 Credits) Vulnerable Patient Feedback: Obtains feedback from vulnerable patient groups on their experiences of disparities in care or services.	
GUIDANCE	EVIDENCE
<p>The practice identifies a vulnerable population where data (clinical quality, resource stewardship, quantitative patient experience, access) show evidence of disparities of care or services.</p> <p>At least annually, the practice obtains qualitative patient feedback from population representatives to acquire better understanding of disparities and to support quality improvement initiatives to close gaps in care.</p>	<ul style="list-style-type: none"> • Report 


[Table of Contents](#)
[Symbol Legend](#)

QI Competency B: Setting Goals and Acting to Improve

Competency B: Setting Goals and Acting to Improve. The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.


QI 08 (Core) Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories:

- A. Immunization measures.
- B. Other preventive care measures.
- C. Chronic or acute care clinical measures.
- D. Behavioral health measures.



GUIDANCE	EVIDENCE
<p>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. At least annually, the practice has an ongoing quality improvement strategy and process that includes a review of performance data and evaluation of performance against goals or benchmarks.</p> <p>Measures selected for improvement may be chosen from the set of measures identified in QI 01. The goal is for the practice to reach a desired level of achievement based on a self-identified standard of care.</p> <p>The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement.</p> <p>The Institute for Healthcare Improvement is a resource for information about the PDSA cycle.</p>	<ul style="list-style-type: none"> • Report <i>OR</i> • Quality Improvement Worksheet <p><i>Note: If measures reported in QI 01 do not leave room for improvement, practices may choose any measure relevant to the patient population for QI 08.</i></p> 

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
<p>The practice has an ongoing quality improvement strategy and process that includes review of performance data and evaluation of performance against goals or benchmarks at least annually. 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.</p>	<ul style="list-style-type: none"> • Report <i>OR</i> • Quality Improvement Worksheet 

QI Competency B: Setting Goals and Acting to Improve

QI 09 Goals and Actions to Improve Resource Stewardship Measures <i>continued</i>	
GUIDANCE	EVIDENCE
<p>Measures selected for improvement may be chosen from the same set of measures identified in QI 02. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.</p> <p>The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement.</p> <p>The Institute for Healthcare Improvement is a resource for information about the PDSA cycle.</p>	 <p>Note: If measures reported in QI 02 do not leave room for improvement, practices may choose any resource stewardship measure relevant to the patient population for QI 09.</p>
QI 10 (Core) Goals and Actions to Improve Appointment Availability: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.	
GUIDANCE	EVIDENCE
<p>Knowing that a variety of factors (e.g., season, patient need, practice resource) can affect appointment availability, the practice can adjust to meet patient preferences and needs.</p> <p>After assessing performance on the availability of common appointment types in QI 03 the practice sets goals and acts to meet the goals at least annually. The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care.</p> <p>Practices that have met their appointment-availability access goals in QI 03 and cannot reasonably adjust their goals or identify room for improvement (practices with open-access scheduling) may select another patient-access area (e.g., time spent in the waiting room, no-show rates, extended hours, alternative visit types) as their focus.</p>	<ul style="list-style-type: none"> • Report <p>OR</p> <ul style="list-style-type: none"> • Quality Improvement Worksheet 

[Table of Contents](#)
[Symbol Legend](#)



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.	
GUIDANCE	EVIDENCE
<p>At least annually, after assessing performance on one patient experience measure (QI 04), the practice sets goals for improving patients' experience of care and acts to meet the goals. The practice desired level of achievement is based on the practice's self-identified standard of care.</p>	<ul style="list-style-type: none"> • Report <p>OR</p> <ul style="list-style-type: none"> • Quality Improvement Worksheet 
QI 12 (2 Credits) Improved Performance: Achieves improved performance on at least two performance measures.	
GUIDANCE	EVIDENCE
<p>The practice demonstrates that it has improved performance on at least two measures. Demonstration of improvement is determined by the goals set in QI 08, QI 09 or QI 11.</p>	<ul style="list-style-type: none"> • Report <p>OR</p> <ul style="list-style-type: none"> • Quality Improvement Worksheet 
QI 13 (1 Credit) Goals and Actions to Improve Disparities in Care/Services: Sets goals and acts to improve performance on at least one measure of disparities in care or services.	
GUIDANCE	EVIDENCE
<p>After assessing performance in care or services among vulnerable populations (QI 05). At least annually, the practice identifies disparities, sets goals and acts to meet the goals.</p>	<ul style="list-style-type: none"> • Report <p>OR</p> <ul style="list-style-type: none"> • Quality Improvement Worksheet 
QI 14 (2 Credits) Improved Performance for Disparities in Care/Services: Achieves improved performance on at least one measure of disparities in care or service.	
GUIDANCE	EVIDENCE
<p>The practice demonstrates that it has improved performance on at least one measure related to disparities in care or service. Demonstration of improvement is determined by the goals set in QI 13.</p>	<ul style="list-style-type: none"> • Report <p>OR</p> <ul style="list-style-type: none"> • Quality Improvement Worksheet 

[Table of Contents](#)
[Symbol Legend](#)



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
<p>At least annually, the practice provides individual clinician or practice-level reports to clinicians and practice staff that include:</p> <ul style="list-style-type: none"> One clinical quality measure. One resource stewardship measure. One patient experience measure. <p>Performance results reflect care provided to all patients in the practice (relevant to the measure), not only to patients covered by a specific payer.</p> <p>The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).</p>	<ul style="list-style-type: none"> Documented process <p>AND</p> <ul style="list-style-type: none"> Evidence of implementation <div style="text-align: center; margin-top: 20px;">  <p>PCSP QI 09 <i>Documented process only</i></p> </div>
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
<p>At least annually, the practice shares individual clinician or practice-level reports with patients and the public that include:</p> <ul style="list-style-type: none"> One clinical quality measure. One resource stewardship measure. One patient experience measure. <p>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.</p> <p>The practice may use data that it produces, or data provided by affiliated organizations (e.g., larger medical group, individual practice association or health plans).</p>	<ul style="list-style-type: none"> Documented process <p>AND</p> <ul style="list-style-type: none"> Evidence of implementation <div style="text-align: center; margin-top: 20px;">  <p>PCSP QI 10 <i>Documented process only</i></p> </div>

[Table of Contents](#)
[Symbol Legend](#)



QI Competency C: Reporting Performance

QI 17 (2 Credits) Patient/Family/Caregiver Involvement in Quality Improvement: Involves the patient/family/caregiver in quality improvement activities.	
GUIDANCE	EVIDENCE
<p>The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's Patient and Family Advisory Council (PFAC).</p> <p>The process specifies how patients and families are selected, their role on the quality improvement team, the frequency of team/PFAC meetings and is reviewed at least annually.</p> <p>The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.</p>	<ul style="list-style-type: none"> • Documented process <p>AND</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  </div>
QI 18 (2 Credits) RETIRED IN 2026	
QI 19 (Maximum 2 Credits) Value-Based Payment Arrangements: Engages in a value-based payment arrangement.	
A. Practice engages in upside risk. (1 Credit)	
B. Practice engages in two-sided risk. (2 Credits)	
GUIDANCE	EVIDENCE
<p>The practice demonstrates that it participates in a value-based arrangement by providing information about its participation or a copy of an executed agreement.</p> <p>Value-based arrangements represent a shift from fee-for-service billing to compensating practices and providers for administering quality care to patients. Participation in these programs signals that a practice is willing to be accountable for the value of care it provides, rather than the volume of care.</p> <p>Upside risk. The clinician/practice receives an incentive for meeting performance expectations, but does not share losses if costs exceed targets.</p> <p>Two-sided risk. The clinician/practice receives incentives for meeting performance expectations regarding quality and cost, and incurs penalties if it does not.</p>	<ul style="list-style-type: none"> • Agreement <p>OR</p> <ul style="list-style-type: none"> • Evidence of implementation <div style="text-align: center; margin-top: 20px;">  <p style="margin: 0;">PCSP QI 13</p> </div>

[Table of Contents](#)
[Symbol Legend](#)

QI Competency D: Clinician and Care Team Experience

Competency D: Clinician and Care Team Experience. The practice measures to understand its current performance and to identify opportunities for improvement.

QI 20 (1 Credit) Assessment of Clinician and Care Team Experience: The organization assesses clinician and care team experience for delivering care.	
GUIDANCE	EVIDENCE
<p>The organization assesses clinician and care team experience delivering care in person and through virtual modalities (if applicable). The organization may consider assessing the following experiences:</p> <ul style="list-style-type: none"> Assessing ease of use and reliability of the electronic health record. Assessing ease of use and reliability of the virtual care platform, if applicable. Confidence in the organization's educational materials regarding patients' health literacy levels. Barriers or restrictions to virtual care, including contracting or licensure requirements. Adequate time with and between patients, including standards of panel size (i.e., how many patients can be treated by the same provider). Clinician burnout. <p>Note: Organizations may choose to use the following validated assessment tool to assess for clinician burnout: <i>The Stanford Model of Professional Fulfillment™</i>¹</p> <p>¹https://wellmd.stanford.edu/about/model-external.html</p>	<ul style="list-style-type: none"> Documented process <p>AND</p> <ul style="list-style-type: none"> Report 
QI 21 (1 Credit) Goals and Actions to Improve Clinician and Care Team Experiences: The organization identifies at least one opportunity to improve the clinician and care team's experience, implements an intervention and measures the intervention's effectiveness.	
GUIDANCE	EVIDENCE
<p>The organization identifies at least one opportunity to improve the clinician and care team experience then implements interventions and measures its effectiveness.</p>	<ul style="list-style-type: none"> Report <p>OR</p> <ul style="list-style-type: none"> Quality Improvement Worksheet 

[Table of Contents](#)
[Symbol Legend](#)