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Physician Practice Connections

PPC1: Access and Communication points

The practice has standards for access to care and communication with patients, and monitors its performance to meet the standards.

Intent

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

Element A - Access and Communication Processes points

	Yes	No	NA
The practice establishes in writing standards for the following processes to support patient access:			
1. scheduling each patient with a personal clinician	☐	☐	
2. coordinating visits with multiple clinicians and/or diagnostic tests during one trip	☐	☐	
3. determining through triage how soon a patient needs to be seen	☐	☐	
4. maintaining the capacity to schedule patients the same day they call	☐	☐	
5. scheduling same day appointments based on practice's triage of patients' conditions	☐	☐	
6. scheduling same day appointments based on patient's requests	☐	☐	
7. providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time	☐	☐	
8. providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week	☐	☐	
9. providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time	☐	☐	
10. providing an interactive practice Web site	☐	☐	
11. making language services available for patients with limited English proficiency.	☐	☐	☐

Scoring

100%	75%	50%	20%	0%
Practice has written process for 9-11 items	Practice has written process for 7-8 items	Practice has written process for 4-6 items	Practice has written process for 2-3 items	Practice has written process for 0-1 items

Data source

Documented process, Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: ABIM

Condition Specific: No

Details: The practice should have standards for staff to respond to requests during office hours as well as to urgent concerns after hours. The following points apply to particular items:

- Item 7—Staff return patient calls within a time frame specified by the practice's policies
- Item 8—A phone message that only directs patients to the emergency room after hours does not meet the standard
- Items 9 and 10—Some practices use secure e-mail or an interactive Web site, either attached to the practice or from an external organization, for making appointments, communicating test results, renewing prescriptions or other nonurgent needs.

- Item 11—Where applicable, practices should utilize interpretation services.

Examples

Data Source: Written procedures for staff for appointments, triage and patient communication; log or schedule to demonstrate capacity (item 3).

Element B - Access and Communication Results			points
	Yes	No	NA
The practice's data shows that it meets access and communication standards in 1A:			
1. visits with assigned personal clinician for each patient	☐	☐	
2. appointments scheduled to meet the standards in items 2-6 in 1A	☐	☐	
3. response times to meet standards for timely response to telephone requests	☐	☐	
4. response times to meet its standards for timely response to e-mail and interactive Web requests	☐	☐	
5. language services for patients with limited English proficiency.	☐	☐	☐

Scoring

100%	75%	50%	20%	0%
Practice's data meets 5 items	Practice's data meets 4 items	Practice's data meets 3 items	Practice's data meets 2 items	Practice's data meets 0-1 items

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic - Intermediate

Source of Content: ABIM

Condition Specific: No

Details: The tracking reports should show that the practice meets its own standards for access through appointments, telephone calls, and e-mail or interactive Web site where applicable.

The practice can do spot checks for these items, such as monitoring appointment wait times and telephone response times for a week to determine how well it meets standards.

The practice may respond "not applicable" (NA) to item 5 if its patient population does not require language services.

Examples

Data Source: Tracking reports, either paper or screen shots, showing records for a period of appointments with personal clinicians, average wait for appointments, average time for returning telephone calls and emails.

PPC2: Patient Tracking and Registry Functions points

The practice systematically manages patient information and uses the information for population management to support patient care.

Intent

The practice has readily accessible, clinically useful information on patients that enables it to treat patients comprehensively and systematically.

Element A - Basic System for Managing Patient Data points

Yes No

The practice uses an electronic data system for patients that includes the following searchable patient information:

1. name

2. date of birth

3. gender

4. marital status

5. language preference

6. voluntarily self-identified race/ethnicity

7. address

8. telephone (primary contact number)

9. e-mail address

10. internal ID

11. external ID

12. emergency contact information

13. current and past diagnoses

14. dates of previous clinical visits

15. billing codes for services.

Scoring

100%	75%	50%	20%	0%
12-15 items were entered for 75-100% of patients	8-11 items were entered for 75-100% of patients	6-7 items were entered for 75-100% of patients	4-5 items were entered for 75-100% of patients	0-3 items were entered for 75-100% of patients

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: Modification to PPC 2004-2005

Condition Specific: No

Details: A practice management system or registry may enable the practice to meet this element; an EHR or more sophisticated system should include this basic data also.

This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice should query its electronic registry, practice management system or other electronic system(s) to obtain data as follows:

- Denominator = total number of patients seen by the practice at least once in the last three months
- Numerator = number of those patients for whom each item is entered.

The report should show how many items are entered for 75 percent to 100 percent of patients.

Examples

Data Source: Reports from electronic systems.

Element B - Electronic System for Clinical Data		points
	Yes	No
The practice's clinical data system or systems to manage care of all patients include the following clinical patient information in searchable coded data fields:		
1. status of age-appropriate preventive services (immunizations, screenings, counseling)	☐	☐
2. allergies and adverse reactions	☐	☐
3. blood pressure	☐	☐
4. height	☐	☐
5. weight	☐	☐
6. body mass index (BMI) calculated	☐	☐
7. laboratory test results	☐	☐
8. presence of imaging results	☐	☐
9. presence of pathology reports	☐	☐
10. presence or absence of advance directives.	☐	☐

Scoring

100%	75%	50%	20%	0%
System has 9-10 data fields	System has 7-8 data fields	System has 5-6 data fields	System has 3-4 data fields	System has 0-2 data fields

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Intermediate

Source of Content: IOM EHR Letter Report

Condition-Specific: No

Details: For this element, the system may be a registry, electronic health record or combination of systems. The practice uses its systems for internally generated clinical data. All items should be kept in coded form; for items 8–10, data may indicate the presence of a written report not in the system.

Examples

Data Source: Screen shots or reports showing fields in patient records. Where applicable, these fields may show that the patient has no allergies or lab or imaging tests.

Element C - Use of Electronic Clinical Data points

The practice uses the fields listed in 2B consistently in patient records.

[In the box to the right, enter the percentage of patients]

Scoring

100%	75%	50%	20%	0%
75-100% of patients seen in the past 3 months have at least 7 fields completed	50-74% of patients seen in the past 3 months have at least 7 fields completed	25-49% of patients seen in the past 3 months have at least 7 fields completed	10-24% of patients seen in the past 3 months have at least 7 fields completed	Less than 10% of patients seen in the past 3 months have at least 7 fields completed

Data source

Records or files

Scope of review: ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Intermediate

Source of Content: IOM

Condition-specific: No

Details: This element calls for calculation of a percentage that generally requires a numerator and a denominator. The practice should query its electronic registry, practice management system or other electronic systems to obtain data as follows:

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom at least seven fields are entered.

The report must show the percent of patients seen in the last three months for whom the practice has entered at least seven of the items in 2B.

If the system has capability to store items in data fields but the practice does not use it, the practice may receive an override score of 20% credit.

Examples

Data source: Reports from electronic system.

Element D - Organizing Clinical Data	points

The practice uses the following electronic or paper-based charting tools to organize and document clinical information in the medical record:
1. problem lists
2. lists of over-the-counter medications, supplements and alternative therapies
3. lists of prescribed medications including both chronic and short-term
4. structured template for age-appropriate risk factors (at least 3)
5. structured templates for narrative progress notes.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	20%	0%

75-100% of records of patients seen in the past 3 months include at least 3 tools with information documented	50-74% of records of patients seen in the past 3 months include at least 3 tools with information documented	25-49% of records of patients seen in the past 3 months include at least 3 tools with information documented	10-24% records of patients seen in the past 3 months include at least 3 tools with information documented	Less than 10% of patient records include at least 3 tools

Data source

Records or files

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: ABIM, IOM EHR Letter Report

Condition-specific: No

Details: Use of charting tools encourages clinicians to be consistent when they document patient information and findings. This element measures the degree of use of a systematic process that does not rely on the clinicians' memory to document certain clinical information—the paper or electronic tool prompts them to do so. Further, the charting tools require a response to each item, prompting the clinician to note either the presence of problems, prescribed medications and risk factors or that the patient has none.

Item 4, age-appropriate risk factor assessments, should come from evidence-based guidelines. Examples are:

- use of tobacco for age 12 and over
- cognitive assessment for new patients over 75
- use of alcohol for age 15 and over
- risk of falls for the elderly
- secondhand smoke
- use of seat belts
- use of bike helmets.

Item 4 requires the practice to record assessment findings for three age-appropriate risk factors (i.e., smoking—no history, alcohol—1 beer per day, weight—170lbs, height—5'1"). The practice should show it documents assessment of age-appropriate risk factors in its electronic system or paper flow sheet, questionnaire or checklist at every appropriate visit. Age-appropriate risk factors may include, but are not limited to, mental health concerns, tobacco use, substance abuse, obesity, at-risk sexual behavior, violence, dementia or family

history of cancer or diabetes.

This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

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

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom three tools have information entered.

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

- Denominator = the sample of patient medical records using NCQA's sampling method in the Record Review Worksheet.
- Numerator = the patients from the medical record review for whom three tools are completed.

To receive credit the practice must show the percentage of patients seen in the past three months for whom the practice has documented information in the charting tools.

Examples

Data source: Medical record review.
Charting tools in the medical record may be paper-based or electronic templates or paper-based flow sheets. An EHR or a paper-based flow sheet may include several of the tools listed.

Element E - Identifying Important Conditions	points	
	Yes	No
The practice uses an electronic or paper-based system to identify the following diagnoses and conditions: 1. practice's most frequently seen diagnoses	□	□

2. most important risk factors in the practice's patient population

3. three conditions that are clinically important in the practice's patient population.

Scoring

100%	75%	50%	20%	0%
Practice identifies 3 items	Practice identifies 2 items	Practice identifies 1 item	No scoring option	Practice identifies 0 items

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: Modification to PPC 2004-2005

Condition-specific: No

Details: This element requires the practice to use data for population management, producing reports on most frequently seen conditions and risk factors, and determining three conditions on which it concentrates care management. To determine the clinically important conditions, the practice analyzes its entire population.

In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

The most frequently seen diagnoses are those that the practice sees most often and may include single episode conditions, such as colds or urinary tract infections, or chronic conditions. The clinically important conditions are chronic or recurring conditions that the practice sees such as otitis media, asthma, diabetes or congestive heart failure. In some cases, the most frequently seen conditions may be the same as the clinically important conditions.

The practice can use any of the following criteria to identify the most frequently seen diagnoses, the most important risk factors and the three important conditions:

- Number of patients with the conditions, problems or risk factors
- Number of visits for the conditions or problems
- Total fees billed or other measures of cost associated with the conditions or problems, or risk factors

In addition, the practice can also use the following criteria to identify the three

important conditions:

- Ability to treat or change the conditions or problems (how amenable the conditions are to care management; whether clinical guidelines are available)

- Other evidence such as conditions for which the practice is measuring performance or receiving rewards for performance; conditions that the practice has selected or targeted to improve performance.

Examples

Data Source: Reports

Element F - Use of System for Population Management	points	
	Yes	No
The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, as follows:		
1. patients needing pre-visit planning (obtaining tests prior to visit, etc.)	☐	☐
2. patients needing clinician review or action	☐	☐
3. patients on a particular medication	☐	☐
4. patients needing reminders for preventive care	☐	☐
5. patients needing reminders for specific tests	☐	☐
6. patients needing reminders for follow-up visits such as for a chronic condition.	☐	☐

Scoring

100%	75%	50%	20%	0%
Practice uses information to take action on 5-6 items	Practice uses information to take action on 3-4 items	Practice uses information to take action on 1-2 items	No scoring option	Practice does not use information to take action

Data source

Reports

Scope of review

Explanation **IT Required:** Intermediate

Source of Content: Expert Panel, Modification to PPC 2004-2005

Condition-specific: No

Details: The electronic system provides practice-wide reports on any of the following fields: demographic information, contact information such as zip codes, imaging tests, laboratory tests, prescription medications, over-the-counter medications, diagnosis or treatment codes, status of preventive health services, risk factors. The practice uses information from the reports to manage specific populations of patients (e.g., patients with diabetes).

The practice also shows how it uses the reports to remind patients of needed services. The practice reminds patients by mail, telephone or electronic mail when services are due. For instance, in addition to the report showing the number of patients eligible for mammograms, the practice provides evidence or a brief statement describing how it reminds those patients to get mammograms.

Some common uses of the population management function would be these or similar items:

- Identify all patients who are taking a medication for which the practice received a warning.
- Identify all patients with ischemic vascular disease not taking appropriate medication.
- Identify all women over 50 who are due for a mammogram.
- Identify all adult patients with elevated LDL for whom appropriate medication has not been prescribed.
- Identify all diabetic patients whose HbA1c is over 9.
- Identify all patients with blood pressure greater than 140/90.

The practice's system needs to link the decision rules to the relevant patient-specific data, such as demographics, age, ICD diagnosis codes, CPT procedure codes, test results, medication and clinical data (blood pressure, weight or BMI smoking status, etc.).

If the system has the capability to generate lists but has not used it, the practice may receive an override score of 20 percent.

Examples **Data Source:** The practice provides computerized reports or screen shots and one of the following two options showing use of information in the reports:

- a written description of the process

- examples of use of the reports (see the bulleted list in the details).

PPC3: Care Management points

The practice systematically manages care for individual patients according to their conditions and needs, and coordinates patients care.

Intent

The practice maintains continuous relationships with patients by implementing evidence-based guidelines and applying them to the identified needs of individual patients over time and with the intensity needed by the patients.

Element A - Guidelines for Important Conditions		points
	Yes	No
The practice adopts and implements evidence-based treatment guidelines for:		
1. first clinically important condition	□	□
2. second clinically important condition	□	□
3. third clinically important condition.	□	□

Scoring

100%	75%	50%	20%	0%
Practice implements guidelines for 3 conditions	No scoring option	Practice implements guidelines for 2 conditions	Practice implements guidelines for 1 condition	Practice does not implement guidelines for any conditions

Data source

Materials

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: Modification to PPC 2004-2005

Condition-specific: Yes

Details: The physicians in the practice adopt evidence-based guidelines and use them. The practice's guidelines must cover three clinically important conditions for its population. The practice's workflow organizers ensure that the guidelines are meaningful to the clinicians in the practice and that they are consistent with the standards of care that the practice wants to follow.

In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

Examples

Data Source: Workflow organizers, which demonstrate both adoption and

implementation of guidelines by the practice.

- Paper-based organizers—algorithms for developing treatment plans, flow sheets or templates for documenting progress.

- Electronic system organizers (registry, EHR or other system)—screenshots showing templates for treatment plans and documenting progress.

Element B - Preventive Service Clinician Reminders			points
	Yes	No	NA
The practice uses a paper-based or electronic system with guideline-based reminders for the following services when seeing the patient:			
1. age-appropriate screening tests	□	□	□
2. age-appropriate immunizations (e.g., influenza, pediatric)	□	□	□
3. age-appropriate risk assessments (e.g., smoking, diet, depression)	□	□	□
4. counseling (e.g., smoking cessation).	□	□	□

Scoring

100%	75%	50%	20%	0%
Practice uses reminders for 4 items	Practice uses reminders for 3 items	Practice uses reminders for 2 items	Practice uses reminders for 1 item	Practice uses reminders for no items

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic if paper-based system, intermediate if electronic system

Source of Content: CMS, Modification to PPC 2004-2005

Condition-specific: No

Details: This element requires using alerts and reminders across the practice for patients who need particular services. The practice identifies patients by age, gender and status of preventive services, and prompts the clinician at the point of care. The following are examples of types of alerts and reminders:

- Order mammogram
- Assess smoking status and give cessation advice or treatment.

A practice could indicate that a factor is not applicable if the practice's specialties

are not involved with providing preventive services for patients. For example, some surgical specialties may not be involved with identifying and providing reminders for screening tests or age-appropriate immunizations.

Examples **Data Source Example:** Documentation from an electronic system may include reports or screen shots.

Documentation from a paper-based system may include templates, flow sheets, algorithms or reminders.

The practice must show that its clinicians have available decision support for interactions with patients including in-person appointments, telephone calls and e-mail communication.

Element C - Practice Organization			points
	Yes	No	
The members of the practice staff manage patient care in the following ways:			
1. nonphysician staff remind patients of appointments and collect information prior to appointments	□	□	
2. nonphysician staff execute standing orders for medication refills, order tests and deliver routine preventive services	□	□	
3. nonphysician staff educate patients about managing conditions	□	□	
4. nonphysician staff coordinate care with external disease management or case management organizations.	□	□	

Scoring

100%	75%	50%	20%	0%
Staff manage 4 items	Staff manage 3 items	Staff manage 2 items	No scoring option	Staff manage 0-1 items

Data source

Materials

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation **IT Required:** Basic

Source of Content: ABIM

Condition-specific: No

Details: Managing patient care is a team effort that involves all members of the practice who interact with patients (i.e., physicians, nurses, nonclinical staff). The practice uses a team approach in managing patient care. Shared responsibilities are designed to maximize use of each team member's level of training and

expertise. In small practices, this may be designated roles for the physician, the nurse, and the administrative person if there is one. In most practices, the availability of nurse case managers will only be through the patients' health plans or other large organization.

Examples

Data Source: Job descriptions, protocols, standing orders.

Element D - Care Management for Important Conditions points

For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:

1. conducting pre-visit planning with clinician reminders
2. setting individualized care plans
3. setting individualized treatment goals
4. assessing patient progress toward goals
5. reviewing medication lists with patients
6. reviewing self-monitoring results and incorporating them into the medical record at each visit
7. assessing barriers when patients have not met treatment goals
8. assessing barriers when patients have not filled, refilled or taken prescribed medications
9. following up when patients have not kept important appointments
10. reviewing longitudinal representation of patient's historical or targeted clinical measurements
11. completing after-visit follow-up.

[In the box to the right, enter the percentage of patients]

Scoring

100%	75%	50%	20%	0%
75% or more of patients seen in the past 3 months have at least 4 items documented	50-74% of patients seen in the past 3 months have at least 4 items documented	25-49% of patients seen in the past 3 months have at least 4 items documented	11-24% of patients seen in the past 3 months have at least 4 items documented	10% or fewer patients seen in the past 3 months have at least 4 items documented

Data source

Records or files

Scope of review: ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: PPC 2004-2005, ABIM, IOM, AAFP, CMS, PPC research version

Condition-specific: Yes

Details: This element is scored once, from a sample across all three important conditions. In the Support Text/Notes the practice states, the three clinically important conditions. Either in a document or in the Support Text box the practice explains or shows the data used to select the conditions.

Not all patients with important conditions require care management, and those that do require it can benefit from all of the actions called for in this element. The physician may decide that patients already achieving good outcomes do not require care management; in those cases, a notation that the patient has good outcomes would suffice in place of a record of the care management processes.

This element calls for calculation of a percentage which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

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

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom each item is entered.

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

- Denominator = the sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = the patients from the medical record review for whom at least four items are entered

The barriers to be addressed (items 7–9) may include the patients' lack of

understanding, motivation, financial need, insurance issues or transportation problems.

Important appointments (item 9) are those that the practice has requested the patient to make in order to follow standards of care (e.g., follow-up visits for monitoring blood pressure or blood sugar levels). Examples of after-visit follow up (item 10) may include checking with patients to confirm they filled a prescription or received care with a consultant.

Examples of longitudinal of patient data (item 11) may include graphs or flow sheets showing blood pressure, weight or LDL levels over time.

Records may show that the practice performs these functions via phone, individual visits, group visits, e-mail or some combination of these. The practice may also utilize another organization, such as a disease management organization, to perform these functions.

Examples

Data Source: Medical record showing the components of care management.

Element E - Continuity of Care			points
	Yes	No	NA
The practice on its own or in conjunction with an external organization engages in the following activities for patients who receive care in inpatient or outpatient facilities:			
1. identifies patients who receive care in facilities	☐	☐	
2. systematically sends clinical information to the facilities with patients	☐	☐	
3. reviews information from facilities (discharge summary or ongoing updates) to determine patients who require proactive contact outside of patient-initiated visits or who are at risk for adverse outcomes	☐	☐	
4. contacts patients after discharge from facilities	☐	☐	
5. provides or coordinates follow-up care to patients who have been discharged	☐	☐	
6. coordinates care with external disease management or case management organizations, as appropriate	☐	☐	☐
7. communicates with patients receiving ongoing disease management or high risk case management	☐	☐	☐
8. communicates with case managers for patients receiving ongoing disease management or high risk case management.	☐	☐	☐

Scoring	100%	75%	50%	20%	0%

	Activities include 5-8 items	Activities include 3-4 items	Activities include 2 items	No scoring option	Activities include 0-1 items

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: Modified PPC 2004-2005

Condition-specific: No

Details: The practice or external organization reviews data to identify patients who receive inpatient or outpatient care at a facility. A facility may be a hospital, an emergency room, a skilled nursing facility or a surgical center. The practice does not wait for these patients to make an appointment, but contacts them directly. Proactive contact includes assisting patients with appropriate care to prevent worsening of their conditions. After the practice has contacted patients, it ensures they receive follow-up care as necessary. Examples of follow-up care include, but are not limited to, physician counseling, referrals to community resources, disease or case management or self-management support programs.

When a patient requires disease management or case management due to frequent emergency room visits, frequent hospitalizations, clinically important conditions or other reason, the practice maintains continuity of care by regularly communicating with both the patient and the case manager. The practice or external organization has a written protocol describing the schedule for communication and at least one example showing the frequency of communication between case manager and patient and one example of case manager and physician.

Examples

Data Source: May be from the practice itself or from an external case management organization such as a disease management organization with which the practice works. The data sources may include:

- protocols that include the practice's timeframe for patient follow up after an admission or emergency room visit
- protocols for using care plans and patient visit flow sheets
- printout from registry, EHR, hospital emergency room, admitting department or other computerized reports that include a list of identified patients, emergency room visits and inpatient admissions
- manual or electronic patient health/needs assessments

- blinded case management or medical record notes.

PPC4: Patient Self-Management Support points

The practice works to improve patients' ability to self-manage health by providing educational resources and ongoing assistance and encouragement.

Intent

The practice collaborates with patients to pursue their goals for optimal achievable health.

Element A - Documenting Communication Needs points

	Yes	No
The practice assesses patient-specific barriers to communication using a systematic process to: 1. identify and display in the record the language preference of the patient	☐	☐
2. assess additional barriers to communication (literacy, hearing, vision).	☐	☐

Scoring

100%	75%	50%	20%	0%
Practice assesses 2 items	No scoring option	Practice assesses 1 item	No scoring option	Practice does not assess any items

Data source

Documented process, Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: Modification to PPC 2004-2005, ABIM

Condition Specific: No

Details: For this element, the practice provides documentation of a systematic process for prompting clinicians to assess language preference and other communication barriers. This element requires a systematic process that does not depend on practice staff remembering to assess the issues—the paper or electronic system prompts the practice's staff member to do so.

Examples

Data Source: Documents that show how the practice records language preference (e.g., screen shots, patient assessment forms) and how the practice determines the percentage of its patients that prefer another language (e.g., reports from an electronic system, review of a sample of records).

Element B - Self-Management Support points

The practice conducts the following activities to support patient self-management, for the three important conditions:
1. assesses patient preferences, readiness to change and self-management abilities
2. provides educational resources in the language or medium that the patient understands
3. provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients to record results in the home setting where applicable
4. provides or connects patients to self management support programs
5. provides or connects patients to classes taught by qualified instructors
6. provides or connects patients to other self-management resources where needed.

[In the box to the right, enter the percentage of patients]

Scoring	100%	75%	50%	20%	0%
	75%-100% of patients seen in the past 3 months have at least 3 activities documented	50%-74% of patients seen in the past 3 months have at least 3 activities documented	25%-49% of patients seen in the past 3 months have at least 3 activities documented	11%-24% of patients seen in the past 3 months have at least 3 activities documented	10% or less patients seen in the past 3 months have at least 3 activities documented

Data source

Records or files

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>**IT Required:** < support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>Basic

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>**Source of Content:** Modification to PPC 2004-2005, CMS

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>**Condition-Specific:** No

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>**Details:** This element addresses the practice helping patients manage their health. This element goes beyond physician counseling or guidance during an office visit. The practice or its medical group may provide self-management programs or classes or it may refer to community resources.

This element calls for calculation of a percentage, which generally requires a numerator and a denominator. The practice may use one of the following methods to calculate the percentage:

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

- Denominator = total number of patients seen at least once by the practice in the last three months
- Numerator = number of those patients for whom each item is entered.

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

- Denominator = the sample of patient medical records using NCQA's sampling method in the Record Review Worksheet
- Numerator = the patients from the medical record review for whom at

least three items are entered

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>Not all patients with important conditions require self-management support, and those that do require it can benefit from all of the actions called for in this element. The physician may decide that patients already achieving good outcomes do not require self-management support; in those cases, a notation that the patient has good outcomes would suffice in place of a record of the self-management items in this element.

< support and counseling visits, group include resources, management self other #7, of Example education. asthma diabetes instructors, by taught classes #5, programs. cessation smoking loss weight programs, #4, Examples forms. self-assessment questionnaires change, to readiness assessing #1,>Examples of item 1, assessing readiness to change, include questionnaires and self-assessment forms. Examples of item 4, self management programs, include weight loss and smoking cessation programs. Examples of item 5, classes taught by instructors, include diabetes and asthma education. Examples of item 7, other self management resources, include group visits, counseling and support groups.

Examples **Data Source:** Medical record review includes:

- referrals to programs, classes or other self-management resources from the patient record
- use of tool for assessing patient preferences, readiness to change and self-management abilities
- use of educational brochures, pamphlets and video

- self-monitoring tool or personal health record.

PPC5: Electronic Prescribing points

The practice employs electronic systems to order prescriptions, to check for safety and to promote efficiency when prescribing.

Intent

The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions and by using drug safety checks and cost information when prescribing.

Element A - Electronic Prescription Writing points

The practice uses an electronic system to write prescriptions using either:
1. electronic prescription writer stand-alone system (general) with either print capability at the office or ability to send fax or electronic message to pharmacy
2. electronic prescription writer that is linked to patient-specific demographic and clinical information.

Select the choice that most closely reflects the practice's performance.

- 75-100% of new prescriptions for patients seen in the last 3 months written with item 2
- 75-100% of new prescriptions for patients seen in the last 3 months written with item 1
- Practice has system capable of doing either item 1 or item 2, but practice does not use
- System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Scoring

100%	75%	50%	20%	0%
75-100% of new prescriptions for patients seen in the last 3 months written with item 2	75-100% of new prescriptions for patients seen in the last 3 months written with item 1	No scoring option	Practice has system capable of doing either item 1 or item 2, but practice does not use	System does not have capability or less than 75% of prescriptions written with item 1 or item 2

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Intermediate

Source of Content: *Electronic Prescribing: Toward Maximum Value and Rapid Adoption, A Report of the Electronic Prescribing eHealth Initiative, April 14, 2004*

Condition Specific: No

Details: This element calls for calculation of a percentage that generally requires a numerator and a denominator. The practice may use one of the methods in

element 2A to calculate the percentage.

The term **general** in all the prescribing elements refers to information about medications from standard data bases. The term **patient-specific** refers to information that is related or linked to data on a particular patient.

Examples

Data Source: Reports from system.

Element B - Electronic Prescribing Interoperability		points
	Yes	No
The practice uses an electronic prescription writer with the following capabilities:		
1. connection to pharmacies	□	□
2. connection to a pharmacy benefit manager	□	□
3. ability to receive renewal requests electronically.	□	□

Scoring

100%	75%	50%	20%	0%
Practice uses writer with capability to do 2-3 items	Practice uses writer with capability to do 1 item	No scoring option	No scoring option	Writer does not have capability

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Advanced

Source of Content: CMS

Condition Specific: No

Details: In some states, connection to pharmacy is illegal. For practices in those states, item 1 is not applicable until the state law is changed.

Examples

Data Source Example: Reports from the system, paper or electronic, showing an example of use of each item.

Element C - Prescribing Decision Support Safety	points

Clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, including the following types of alerts and information:
1. drug-drug interactions based on general information
2. drug-drug interactions specific to drugs the patient takes
3. drug-disease interactions based on general information
4. drug-disease interactions specific to diseases the patient has
5. drug-allergy alerts based on general information
6. drug-allergy alerts specific to the patient
7. drug-patient history alerts based on general information
8. appropriate dosing based on general information
9. appropriate dosing calculated for the patient
10. therapeutic monitoring associated with specific drug utilization based on general information (drug-lab alerts)
11. duplication of drugs in a therapeutic class based on general information
12. duplication of drugs in a therapeutic class specific to the patient
13. drugs to be avoided in the elderly based on general information
14. drugs to be avoided in the elderly based on age of the patient
15. patient-appropriate medication information.

- Practice uses 8 or more kinds of alerts and information
- Practice uses 4 to 7 kinds of alerts and information
- Practice uses 2 to 3 kinds of alerts
- System has capability of providing 6 or more kinds of alerts, but practice does not use them
- No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

Scoring

100%	75%	50%	20%	0%
Practice uses 8 or more kinds of alerts and information	Practice uses 4 to 7 kinds of alerts and information	Practice uses 2 to 3 kinds of alerts	System has capability of providing 6 or more kinds of alerts, but practice does not use them	No system capability, system has capability for fewer than 6 kinds of alerts or practice uses fewer than 2 kinds of alerts and information

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Advanced if practice obtains patient-specific data on filled prescriptions, Intermediate for all general alerts and for patient-specific alerts using internal data on prescribed medications.

Source of Content: eHealth Initiative, CMS, NCQA, US Pharmacopoeia

Condition Specific: No

Details: The practice's electronic system should alert clinicians to specific prescribing issues for patient safety.

Addressed by this element are:

- Standalone electronic prescription reference tools that provide **general** automatic alerts—these could meet the factors that call for general information
- Electronic prescription writers or EHRs that provide **general** automatic alerts—these could also meet the factors that call for **general** information
- Electronic prescription writers or EHRs that provide **patient-specific** drug and medication management information. These utilize a list of medications a patient is taking, as well as other patient-specific information to generate alerts. These tools should also generate alerts based on general information, as the clinician can not assume that all needed patient-specific information is available electronically in the practice's system. Patients may have history, diagnoses or medications that the practice's system has not captured.

NCQA has first-year HEDIS specifications for items 10 and 13. In the future, national organizations may provide more specifications to standardize some of these types of alerts. Systems should have the capability of adding specific alerts as specifications become available.

Examples

Data Source: Reports from the system, paper or electronic, showing an example of use of each item.

Element D - Prescribing Decision Support—Efficiency points

Clinicians engage in cost-efficient prescribing through one or more of the following tools:

1. electronic prescription writer with general automatic alerts for alternative medications including generics

2. electronic prescription writer connected to patient-specific formulary
that automatically alerts clinician to alternative drugs, including generics.

Select the choice that most closely reflects the organization's performance.

- Practice uses 2 tools
- Practice uses 1 tool
- System has capability to support both options; practice does not use it
- System does not have capability or practice does not use either tool

Scoring

100%	75%	50%	20%	0%
Practice uses 2 tools	Practice uses 1 tool	No scoring option	System has capability to support both options; practice does not use it	System does not have capability or practice does not use either tool

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Advanced if checks are patient-specific (requires connection to formulary); Intermediate if general checks.

Source of Content: Modification to PPC 2004-2005

Condition Specific: No

Details: The practice's electronic system should alert the clinician to the most cost-effective of the choices for the patient, including generic drugs. The most effective type of tool actually connects with or downloads the formulary for the patient's health plan, to alert the clinician to the most efficient choice for the patient.

Examples

Data Source: Reports from the system, screen shots, practice protocols.

PPC6: Test Tracking points

The practice systematically tracks tests ordered and test results, and systematically follows up with patients.

Intent

The practice works to improve effectiveness of care, patient safety and efficiency by using timely information on all tests and results.

Element A - Test Tracking and Follow Up points

The practice systematically does the following:
1. tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
2. tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
3. flags abnormal test results, bringing them to a clinician's attention
4. follows up with patients for all abnormal test results.

Select the choice that most closely reflects the practice's performance.

- Practice does all 4 types of tracking and follow-up
- Practice does 3 types of tracking and follow-up
- Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it
- Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Scoring

100%	75%	50%	20%	0%
Practice does all 4 types of tracking and follow-up	No scoring option	Practice does 3 types of tracking and follow-up	Practice's electronic system has the capability to do all 4 types of tracking and follow-up but practice does not use it	Practice's system does not have capability to track, or the practice does fewer than 3 types of tracking and follow-up

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic if paper system, intermediate if electronic system within the

office, advanced if interconnected with laboratory or radiology

Source of Content: PPC 2004-2005

Condition Specific: No

Details: Whether the system is manual or electronic, there must be evidence that the practice reviews and uses the log before or at the beginning of every patient appointment. There must be evidence that the practice both follows up with the clinician and proactively notifies the patient of abnormal results; filing the report in the medical record for the next time the patient comes in does not meet the intent of the standard.

Examples

Data Source: Reports or logs may be a paper log or an electronic in-box showing outstanding tests and showing how the practice flags abnormal results.

Element B - Electronic System for Managing Tests	points Yes	No
The practice uses an electronic system to:		
1. order lab tests		
2. order imaging tests		
3. retrieve lab results directly from source		
4. retrieve imaging text reports directly from source		
5. retrieve images directly from the source		
6. route and manage current and historical test results to appropriate clinical personnel for review, filtering and comparison		
7. flag duplicate tests ordered		
8. generate alerts for appropriateness of tests ordered.		

Scoring

100%	75%	50%	20%	0%
Practice uses 5-8 functions	Practice uses 3-4 functions	Practice uses 1-2 functions	No scoring option	Practice does not use system

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Advanced

Source of Content: Modification to PPC 2004-2005

Condition Specific: No

Details: This element assumes electronic communication between the practice and the lab and imaging facilities, as well as electronic alerts generated by or for the practice.

If the practice has electronic capability to manage tests but has not used it, it may receive an override score of 20 percent.

Examples

Data Source: Reports or screen shots from the system showing examples of each of the functions.

PPC7: Referral Tracking points

The practice systematically documents and tracks referrals and referral results.

Intent

The practice seeks to improve effectiveness, timeliness and coordination of care by following through on consultations with other practitioners.

Element A - Referral Tracking points

	Yes	No
Outside of paper medical records and patient visits, the practice uses a paper-based or electronic system to assist in tracking practitioner referrals designated as critical until the consultant report returns to the practice. The practice uses a system that includes the following information for its referrals:		
1. origination	☐	☐
2. clinical details	☐	☐
3. tracking status	☐	☐
4. administrative details.	☐	☐

Scoring	100%	75%	50%	20%	0%

	Practice uses system that includes all 4 items	Practice uses system that includes 2-3 items	Practice uses system that includes 1 item	No scoring option	System does not include any of the items

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic or advanced. (Basic for paper system; advanced for electronic system).

Source of Content: HL-7 Functional standards and Expert Panel

Condition Specific: No

Details: Origination includes the referring clinician (the origin of the referral).

Clinical details include the clinical reason for requesting the referral as well as relevant clinical findings.

Administrative details include insurance information, including whether the referral requires health plan approval.

Tracking status includes whether or not the consultant report has returned to the practice.

A critical referral is determined by the physician to be important to the treatment of the patient or indicated by practice guidelines. An example would be a referral to a breast surgeon for examination of a possibly cancerous lump.

Examples

Data Source: Written logs or other paper-based documents if not electronic, reports from the system if electronic.

Element B - Referral Decision Support		points
	Yes	No
The practice uses a paper or electronic system for decisions on referrals at the time of the referral, as follows:		
1. determine that there are duplicate requests for referrals	☐	☐
2. consider available quality performance reports on consultants or facilities.	☐	☐

Scoring	100%	75%	50%	20%	0%

Evidence of use of 2 types of information	No scoring option	Evidence of use of 1 type of information	No scoring option	No evidence of use of information

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic or intermediate for item 1; basic for item 2

Source of Content: Expert Panel

Condition Specific: No

Details: For item 1, the clinician should have access to information that shows whether he/she is ordering a duplicate referral.

For item 2, the practice uses performance information where available to assist in determining the consultants or facilities to use. This factor does not require electronic alerts.

Examples

Data Source: For item 1, screen shots or reports. For item 2, performance reports, where available, such as public reports on surgery outcomes.

PPC8: Performance Reporting and Improvement points

The practice regularly measures its performance and takes actions to continuously improve.

Intent

The practice seeks to improve effectiveness, efficiency, timeliness and other aspects of quality by measuring and reporting performance, comparing itself to national benchmarks, giving physicians regular feedback and taking actions to improve.

Element A - Measures of Performance points

	Yes	No
The practice measures or receives data on the following types of performance by physician or across the practice:		
1. clinical process (e.g., percentage of women 50+ with mammograms)	□	□
2. clinical outcomes (e.g., HbA1c levels for diabetics)	□	□
3. service data (e.g., backlogs or wait times)	□	□

4. patient safety issues (e.g., medication errors).

5. patient experience of care (e.g., surveys of patients regarding follow-up, communications skills)

Scoring

100%	75%	50%	20%	0%
Practice measures at least 2 types of performance	No scoring option	Practice measures 1 type of performance	No scoring option	No areas of performance measured

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: PPC 2004-2005 and NCQA's PPC Research Version

Condition Specific: No

Details: Performance reports may be generated by the individual practice site, the medical group or individual practice association to which the practice belongs or an affiliated health plan.

The practice may use electronic systems to measure any of these items, but the element requires performance measurement whether or not electronic systems are available.

Examples

Data Source: Reports from:

- manual review of a sample of patient records
- patient surveys
- practice management system
- registry
- health plan-provided data
- larger medical group provided data

- electronic data base.

Element B - Reporting to Physicians points

Yes No

The practice reports on performance on the measures in 8A:

1. across the practice

2. by individual physician.

Scoring

100%	75%	50%	20%	0%
Practice reports to physicians results both across the practice and by physician	No scoring option	Practice reports to physicians results either across the practice or by physician	No scoring option	No areas of performance reported to physicians

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: NCQA's PPC Research Version

Condition Specific: No

Details: The practice may utilize data that it produces itself or data provided by affiliated organizations, such as a larger medical group, individual practice association or health plans. After the practice measures or receives performance data, it reports it to the practice as a whole and to individual physicians.

Examples

Data Source: Blinded reports showing summary practice performance or individual physician performance; blinded letters to physicians showing performance.

Element C - Setting Goals and Taking Action	points

	Yes	No
The practice:		
1. sets goals based on measurement results referenced in Elements 8A and 8B		
2. takes action where identified to improve performance of individual physicians or of the practice as a whole.		

Scoring

100%	75%	50%	20%	0%
Practice does 2 items	No scoring option	Practice does 1 item	No scoring option	Practice does no items

Data source

Reports

Scope of review: ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Basic

Source of Content: Modification to PPC 2004-2005

Condition Specific: No

Details: The practice should base goal setting on its own measurements as in element 8A. Examples of actions taken include providing such assistance as flow sheets or decision support to clinicians to prompt more systematic treatment.

Examples

Data Source: Reports or completion of the PPC Quality Measurement and Improvement worksheet.

Element D - Reporting Standardized Measures points

The practice produces reports on its performance using nationally approved clinical performance measures.

[In the box to the right, enter the number of measures]

Scoring

100%	75%	50%	20%	0%
Practice produces reports using 10 or more nationally approved performance measures	Practice produces reports using 5-9 nationally approved performance measures	Practice produces reports using 3-4 nationally approved performance measures	No scoring option	Practice produces reports using 0-2 nationally approved performance measures

Data source

Reports

Scope of review: ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Intermediate

Source of Content: CMS

Condition Specific: No

Details: The intent is that the practice both measures and has the capability to report performance using measures that are approved by the National Quality Forum. As national measure sets are evolving, the practice should have the ability to report current measures as well as to program the reporting of new measures. Appendix A shows the measures currently approved by the National Quality Forum for use at the physician or practice level.

Reporting these measures requires that the practice have the ability to link a variety of data sources, including:

- standard ambulatory diagnoses and procedure codes (ICD, CPT)
- prescribed medications
- lab tests and results
- radiology data (ordered, results)
- blood pressure (value)
- standard inpatient diagnoses and procedure codes (DRG, CPT, ICD).

Examples

Data Source: Reports showing performance measures calculated by practice.

Element E - Electronic Reporting—External Entities points

The practice electronically reports results on nationally approved measures to the public sector, health plans, or others.

[In the box to the right, enter the number of measures]

Scoring

100%	75%	50%	20%	0%
Practice transmits 10 or more nationally approved performance measures to an external entity	Practice transmits at least 5-9 nationally approved performance measures to an external entity	Practice transmits 3-4 nationally approved performance measures to an external entity	Practice transmits 1-2 nationally approved measures to an external entity	Practice does not transmit any measures

Data source

Reports

Scope of review	ONCE--NCQA scores this element once for the organization.
Explanation	**IT Required:** Advanced **Source of Content:** CMS **Condition Specific:** No **Details:** This element assesses the practice's ability to report measures electronically to external entities. If the system has the capability to transmit measures but has not done so, the practice may receive an override score of 20 percent.
Examples	**Data Source:** Report to payor or other user from practice's electronic system.

PPC9: Interoperability points

The practice uses electronic systems that interconnect with electronic systems from other entities, receiving data from and transmitting data to other systems.

Intent

The practice seeks to improve timeliness, effectiveness, efficiency and coordination of care by using complete and accurate data from all provider sources, centered on the patient.

Element A - Use of Prescribed Standardized Codes points

	Yes	No
The system stores and manipulates patient data in a structured computable manner and uses nationally accepted standard code sets. The practice demonstrates the following:		
1. there is a unique electronic identifier for each patient	☐	☐
2. all providers in the practice have unique identifiers	☐	☐
3. the electronic system uses and maintains clinical information using standardized codes	☐	☐
4. the electronic system uses and maintains codes to identify clinical observation and diagnostic results and allergies	☐	☐
5. the system maintains medication and allergy data using standardized codes.	☐	☐

Scoring	100%	75%	50%	20%	0%

Electronic system maintains and the practice uses 4-5 items	Electronic system maintains and the practice uses 3 items	Electronic system maintains and the practice uses 1-2 items	No scoring option	Electronic system does not maintain and practice does not use any items

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Intermediate

Source of Content: Expert Panel, CMS, HL7, HIPAA

Condition Specific: No

Details: This element concerns the way the practice's system maintains data. There are standards for data storage and codes sets being developed under a contract with Health and Human Services. When these standards are incorporated into a certification program for EHRs, the practice should use the codes prescribed in the standards. As of now, the following are the possible code sets that practice systems should use:

- Patients'practice should use its own identifier.
- Providers'a National Provider Identifier (when it becomes available).
- Clinical information'ICD, CPT, DRG, SNOMED' codes.
- Clinical observations and diagnostic results'LOINC' codes.
- Medication data'RxNorm or NDC codes.

The element requires data stored in a structured manner except in situations when free text or data in a non-electronic form may be more useful to the clinician. An example of free text as the optimal method for maintaining patient information is a clinician's description of a complex patient with multiple symptoms or complaints'structured data may not adequately portray the patient's condition.

If the system has capability to store and manipulate data but the practice has not used it, the practice may receive an override score of 20 percent.

Examples

Data Source: Reports or screen shots demonstrating use of standard codes at patient level.

Element B - Electronically Receiving Data points

Yes No

The practice's EHR or data systems receive and integrate healthcare data

by patient and ordering provider, including:

1. prescription data

2. lab tests and results, including transcription

3. imaging tests and results, including transcription

4. medical histories from other practitioners

5. inpatient data (e.g., DRG, discharge status)

6. clinical observations (e.g., blood pressure, smoking status)

7. self-monitored information from patients who have their own electronic health or personal health record (PHR)

8. encounter data from practitioners or institutions outside the organization with which the practice is regularly affiliated.

Scoring

100%	75%	50%	20%	0%
Practice electronically accepts 6-8 kinds of data	Practice electronically accepts 3-5 types of data	Practice electronically accepts 1-2 types of data	No scoring option	Practice does not accept any of the types of data

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Advanced

Source of Content: Expert Panel and CMS

Condition Specific: No

Details: This element requires the systems of the ordering or rendering provider to receive patient information electronically from other sources. It can be stored in the practice's electronic system.

Item 8 refers to being able to accept data from outside an organization of affiliated practices (i.e., from different medical systems).

If the system has capability to accept data but the practice does not use it, the practice may receive an override score of 20 percent.

Examples

Data Source: Reports of screen shots from the practice's system or EHR showing that external information was received and integrated.

Element C - Electronically Transmitting Data	points	
	Yes	No
The practice's electronic system has the capability to automatically and securely transmit computable health care data by patients and to other health care providers, including practitioners and institutions outside the practice's regular affiliations, using nationally accepted standard message formats as listed in 8B.		
This includes transmitting the following information:		
1. clinical information to other providers including health plans and to patients who have their own PHRs	☐	☐
2. prescription information (ordered, current use, dispensed) to patients and other providers	☐	☐
3. diagnostic (lab, imaging) information (ordered, results) to patients and other providers	☐	☐
4. orders electronically to service providers	☐	☐
5. appointments to other providers and sites.	☐	☐

Scoring

100%	75%	50%	20%	0%
System has the capability to transmit 5 types of data	System has the capability to transmit 3-4 types of data	System has the capability to transmit 1-2 types of data	No scoring option	Practice does not have the capability to transmit data

Data source

Reports

Scope of review

ONCE--NCQA scores this element once for the organization.

Explanation

IT Required: Advanced

Source of Content: Expert Panel, CMS, HL7

Condition Specific: No

Details: This element requires the ordering provider's systems to have the capability of electronically sending information to other sources. The other sources in the exchange include other health care providers such as practitioners and institutions outside the practice's regular affiliations, and patients.

This element assesses the capability of the practice's electronic system; it does not require evidence of actual use. This is an indication of a desirable future state in which a practice can participate in regional health information exchanges.

Examples

Data Source: Reports of flow diagrams and screen shots showing system capability.

Element D - Using Data for Referral Reports		points
	Yes	No
The practice's electronic system has the capability to generate and/or capture electronically the following text fields by patient to generate a referral report:		
1. reason for consultation	☐	☐
2. pertinent physical findings	☐	☐
3. pertinent clinical data as listed in 2B	☐	☐
4. support person	☐	☐
5. functional status	☐	☐
6. family history	☐	☐
7. social history	☐	☐
8. plan of care	☐	☐
9. health care providers.	☐	☐

Scoring

100%	75%	50%	20%	0%
System has the capability to auto produce a referral report that includes 7-9 items	System has capability to auto produce a referral report that includes 4-6 items	System has capability to auto produce a referral report that includes 2-3 items	No scoring option	System has capability to auto produce a referral report that includes 0-1 item or report does not include any of the items

Data source

Reports

Scope of review	ONCE--NCQA scores this element once for the organization.
Explanation	**IT Required:** Advanced **Source of Content:** CMS and Expert Panel **Condition Specific:** No **Details:** The referral report is intended to be a snapshot of clinical and administrative data for a unique patient. It may include patient data either from the referring clinician to the consultant or from the consultant to the referring clinician. This element looks at the system's capability, not at the practice's use of the capability. An example of a referral report is the continuity of care record (CCR).
Examples	**Data Source:** Referral reports from electronic registry or EHR. Policies and procedures for populating and using referral reports.