2027 STANDARDS AND GUIDELINES FOR

ACCREDITATION IN ADVANCED PRIMARY CARE

EFFECTIVE JULY 1, 2027

NCQA
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Improving health care.

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Population Health Management

PHM 1: PHM Program Oversight

The organization establishes oversight for its population health management (PHM) program to guide strategy, execution and quality improvement.

Intent

The organization maintains an effective PHM program through governance, annual planning, communication with patients and clinicians, and oversight of performance and disparities work.

Element A: PHM Governance Structure

The organization maintains a documented PHM governance structure that includes:

1. **Oversight by a committee or equivalent body and clearly defined PHM leadership roles.**
2. **A process for engaging clinicians.**
3. **A process for reviewing population needs and disparities.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews a documented process for PHM oversight is conducted, how the organization engages clinicians and how the organization reviews population needs and disparities.

Look-back period *For All Surveys:* Prior to survey date

Explanation

***Factor 1:* Committee oversight**

The organization has a documented governance structure that includes oversight by a committee or an equivalent body, and defines roles and responsibilities, including accountability for monitoring program performance and program improvement activities.

***Factor 2*: Process for engaging clinicians**

The organization has a process (e.g., structured forums, meeting participation, other feedback mechanisms) for engaging clinicians in PHM governance and activities to inform PHM priorities.

***Factor 3:* Process for reviewing population needs and disparities**

The organization has a process for reviewing population needs and disparities regularly by using available data sources and analyses to identify priority populations, assess performance and inform PHM actions to improve outcomes.

Exceptions

None.

Examples

Factor 1: **Committee oversight**

- PHM governance charter, terms of reference or bylaws that describe responsibilities.
- Committee agendas or meeting minutes documenting review of PHM programs, performance or improvement.

Element B: Annual PHM Plan

The organization annually develops and maintains a PHM plan that:

1. **Identifies PHM priorities and targeted populations based on assessed needs.**
2. **Describes how PHM programs align with those needs.**
3. **Sets goals and outlines key actions for planning period.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *For All Surveys:* Approved PHM plan and evidence of review by the PHM oversight body/committee (meeting minutes).

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

Factor 1: **Identify PHM priorities and targeted populations based on assessed needs**

The organization uses the results from its population needs assessment (PHM 2, Element A) to identify and rank PHM priorities and targeted populations for the planning period. NCQA does not prescribe priorities, populations or areas of focus. The organization determines the priorities and populations based on assessed needs.

Factor 2: **Describe how PHM programs align with assessed needs**

The organization describes how its PHM programs are aligned to the assessed needs and targeted populations identified in factor 1.

The organization may reference existing programs, newly planned initiatives or modifications to current PHM activities, and explains how programs are intended to address identified needs of selected populations. The organization demonstrates how programs can support population needs but is not required to map one-to-one to priorities.

Factor 3: Set goals and key actions

The organization defines SMART goals (specific, measurable, achievable, relevant, time-bound) and key actions that guide execution during the planning period. The intent is to ensure that PHM planning moves beyond high-level strategy and translates priorities into actionable, measurable efforts.

Goals are specific to a target population and reflect the organization's PHM priorities, and may address outcomes such as improved access, quality, care coordination, experience, equity or population health improvement. Key actions describe activities, initiatives or focus areas the organization intends to pursue in support of goals.

This factor does not require organizations to report performance results within the PHM plan itself. It establishes a forward-looking planning expectation that supports accountability, oversight and future evaluation. Goals and actions may align with planning or performance improvement processes across the organization.

Exceptions

None.

Examples

Factor 1: Identifying PHM priorities and targeted populations based on needs

Based on the most recent population needs assessment, the organization identified the following priority needs and targeted populations for the planning period of January–December 2025:

Priority Need 1: Control poor chronic conditions and avoidable utilization

- Targeted population: Adults with diabetes and/or hypertension, with a focus on individuals experiencing frequent ED utilization or recent hospitalizations.

Priority Need 2: Close gaps in behavioral health access and follow-up

- Targeted population: Members with diagnosed depression or anxiety, particularly those with a recent inpatient or ED behavioral health encounter.

Priority Need 3: Health-related social needs affecting care engagement

- Targeted population: Members screening positive for food insecurity, housing instability or transportation barriers, with particular attention to populations experiencing disparities by race, ethnicity or socioeconomic status.

Priorities were based on review of utilization trends, clinical quality measures, behavioral health data, health risk assessments and social risk screening results.

Factor 2: Describing how PHM programs align with assessed needs

Chronic Condition Management Program

- Supports Priority Need 1 by providing care management, outreach and self-management education for members with diabetes and hypertension.

- Interventions include medication adherence support, remote monitoring, and coordination with primary care providers.

Integrated Behavioral Health Support

- Supports Priority Need 2 through referral pathways, follow-up outreach after acute behavioral health events and coordination with behavioral health providers.
- Programs include case management and collaboration with community-based behavioral health resources.

Social Needs Navigation and Community Partnerships

- Supports Priority Need 3 by screening members for social needs and connecting them to internal or community-based resources.
- Interventions include resource referrals, closed-loop referral tracking, where available, and partnerships with community organizations.

Programs represent existing initiatives, newly launched efforts, and modifications to current PHM activities implemented in response to assessed needs.

Factor 3: Setting goals and key actions

Goal 1: Improve chronic disease outcomes

- By the end of the planning period, increase the percentage of members with diabetes who are enrolled in the chronic condition management program and have controlled HbA1c.

Goal 2: Strengthen behavioral health follow-up

- Within the planning period, improve timely follow-up after behavioral health inpatient or ED encounters for targeted members.

Goal 3: Address health-related social needs

- During the planning period, increase the proportion of patients with identified social needs who receive resource referrals or navigation support.

Key actions

- Expand care management outreach for high-risk patients
- Enhance coordination between primary care, behavioral health and care management teams.
- Standardize social needs screening and referral processes.
- Monitor implementation progress through internal oversight and governance processes.

Element C: Communication About PHM Programs

The organization informs:

1. **Patients and clinicians about all appropriate programs.**
2. **Eligible patients about interactive programs.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Materials

Scope of review *For All Surveys:* NCQA reviews evidence of communications.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Informing patients and clinicians**

The organization broadly communicates information about all PHM programs to its patient population and clinicians. Communications describe:

- The purpose of each program.
- Eligibility criteria for each program.
- How patients can participate or use services.
- How patients can opt in or opt out, when applicable.

***Factor 2:* Informing patients about eligible programs**

The organization directly informs eligible patients about PHM programs that are more intensive or that leverage interactive contact. Interactive programs are two-way interaction through one of the following methods:

- Telephone.
- Text messaging.
- In-person contact (individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.
  - Video conference.
- Interactive contact through artificial intelligence (e.g., voice-activated technology).

Targeted communications must be tailored to eligible patients and include information on program benefits and how to enroll or engage.

Exceptions

None.

Examples

***Factor 1*: Information about programs**

Communication materials may include:

- Portal pages.
- Letters.
- Online outreach materials.
- Training materials for clinicians.

***Factor 2:* Informing patients about eligible programs**

- A diabetes outreach program where care team members conduct regular check-ins via portal messages or text messages to review blood sugar logs, assess symptoms, reinforce self-management goals and coordinate follow-up visits.
- A post-discharge follow-up program that includes internal pharmacist or nurse-led outreach via a virtual visit to reconcile medications and escalate concerns to the primary care practitioner when side effects or discrepancies are identified.
- A care management program for patients with multiple chronic conditions or social risk factors that uses face-to-face engagement to review care plans, provide resources and deliver group education sessions.

Element D: Annual PHM Evaluation

The organization:

1. **Completes an annual evaluation of the PHM program.**
2. **Completes a PHM Committee review for action.**
3. **Reports the outreach rate for each program.**
4. **Reports the participation rate for each program.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Materials, Reports

Scope of review

For All Surveys: NCQA reviews:

- *Factors 1–2:* Meeting minutes showing closed-loop review action.
- *Factors 3–4:* Reports of outreach rates and participation rates for interactive programs.

Look-back period

For All Surveys: Prior to the survey date.

Explanation

***Factor 1:* Annual evaluation**

The organization completes an annual evaluation of PHM programs that:

- Summarizes completed and ongoing PHM activities.
- Assesses trends in PHM performance.
- Assesses performance against established PHM program goals (Element B), including whether goals were met, partially met or not met.
- Evaluates program effectiveness, including impact on identified disparities.
- Identifies areas for improvement.

Determining if a goal was met assesses the goal's alignment with the organization's stated objectives; evaluating effectiveness determines if the program produced meaningful results and informs future actions.

***Factor 2:* PHM committee review and action**

The organization's PHM committee reviews the PHM plan and the annual evaluation, and approves proposed improvement actions, oversees implementation and monitors the progress on meeting goals.

***Factor 3:* Outreach rate for each program**

The organization reports the outreach rate by calculating:

- *Numerator:* The number of eligible patients who were informed about each program or service.
- *Denominator:* The total number of eligible patients.

***Factor 4:* Program participation rate**

The organization reports the participation rate by calculating:

- *Numerator:* The number of eligible patients who engaged in each program or service.
- *Denominator:* The total number of eligible patients.

Exceptions

None.

Examples

***Factors 1 and 2:* Annual evaluation and review by committee**

The organization evaluates a diabetes management program.

Metric	Findings	Comparison to Goal
Program Activities	• Identify patients using A1c data. • Care management outreach. • Education sessions about self-management support.	Met
Trends and Effectiveness	• Increased percentage of enrolled patients with controlled A1c. • Reduced ED visits for enrollees.	Not met
Disparities	• Lower enrollment among Hispanic/ Latino patients in rural areas.	Partially met
Identified Areas for Improvement	• Enhanced outreach strategies for patients with limited digital access. • Adjusted program materials for language or health literacy needs.	Met

The PHM Committee reviews the comprehensive evaluation, with meeting minutes documenting discussion and approval of improvement actions.

***Factors 1, 2:* Annual evaluation and review by committee**

PHM priority: Improve outcomes for patients with chronic conditions

Program evaluated: Chronic Condition Management

Planning period: January–December [year]

Goal: By the end of the planning period, increase the percentage of members with diabetes who are enrolled in the chronic condition management program and have controlled HbA1c.

Activities:

- Patient identification using A1c data.
- Care management outreach.
- Education sessions about self-management support.

Evaluation summary:

- Goal achievement: Met.
- Overall program effectiveness: Partially effective.

Findings:

- The program goal was met. There was variation in engagement across subpopulations, which limited overall program effectiveness but helped identify opportunities for improvement.

- There were reductions in ED utilization among program participants, which was attributed to care management.
- There was lower enrollment among Hispanic/Latino patients in rural areas.

Areas for improvement:

- Enhance outreach strategies for patients with limited digital access.
- Adjust program materials for language or health literacy needs.

The PHM committee reviewed the comprehensive evaluation. Meeting minutes document discussion and approval of improvement actions.

Factor 3: Outreach rate example

Evaluate outreach for a diabetes management program:

- Total eligible patients: 1,000.
- Eligible patients informed about the program: 600.
- Ratio: 600/1,000 = 0.60.

Factor 4: Participation Rate Example

Evaluate participation in a diabetes management program:

- Total eligible patients enrolled: 1,000.
- Participating patients: 250.
- Ratio: 250/1000 = 0.25.

PHM 2: Population Identification

The organization systematically collects, integrates and assesses patient data to inform the needs of its population.

Intent

The organization conducts a population needs assessment to define meaningful population segments and actionable categories, including identifying potential bias, to inform appropriate PHM activities.

Element A: Population Needs Assessment

The organization annually assesses the clinical, behavioral, social, cultural and linguistic needs of its patient population, using available data sources.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review *For All Surveys:* NCQA reviews the organization's most recent annual assessment reports.

Look-back period *For All Surveys:* At least once during the prior year.

Explanation Annually, the organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic, demographics) to assess the clinical, behavioral, social, cultural and linguistic needs of its patient population. The assessment considers social determinants of health and other characteristics to inform the structure and resources of PHM programs.

Exceptions

None.

Examples

Potential characteristics

Social determinants of health include, but are not limited to:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.

- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Other characteristics to consider:

- Natural environment such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, benches).
- Multiple chronic conditions or severe injuries.
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Types of Special Needs Plan (SNP) (e.g., Dual Eligible, Institutional, Chronic).
- Age.
- Race.
- Ethnicity.
- Language preference.

Element B: Targeting, Segmentation and Bias Evaluation

The organization:

1. **Segments or stratifies its patient population into meaningful groups for targeted intervention.**
2. **Evaluates segmentation for racial/ethnic or other bias.**
3. **Reviews whether the organization's segmentation or stratification approach is appropriately matching patients to the intended interventions.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports, Documented process

Scope of review

For All Surveys: NCQA reviews:

- *For factor 1:*
  - A description of the methods used to segment or stratify the organization's patient population, including subsets to which patients may be assigned.
  - Reports showing the number of patients in each segment.
- *For factor 2:* The organization's documented process for assessing bias in its segmentation or stratification methodology.
- *For factor 3:* The most recent annual report demonstrating that the organization reviews its segmentation or stratification approach.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

***Factor 1:* Segmentation or stratification**

Population segmentation divides a population into meaningful subsets—patients who share specific needs, characteristics, identities, conditions or behaviors—using information collected through population assessments and other data sources.

Risk stratification divides a population into groups or categories based on potential risk (e.g., lack of preventive screenings, chronic health conditions, poor health outcomes or at risk for hospitalization, high utilization or expense), and then assigns individuals to risk tiers or subsets.

Segmentation and risk stratification categorize individuals with care needs at all levels and intensities, and may use findings from population assessments and data integration (e.g., clinical and behavioral data, population and social needs) to target resources and interventions (e.g., preventive screenings gap closure activities, complex care management or other program access, eligibility for specific services or treatments) to individuals who can most benefit from them.

Methodology. The organization describes its method for segmenting or stratifying its patient population, including the subsets to which patients are assigned. Either process may be used to meet this element. The organization may use more than one method to determine actionable subsets. Segmentation methods for chronic health conditions or health status must be based on nationally recognized guidelines, ICDs or eCQMs.

Although the organization's methods may include utilization/resource use or cost information (e.g., claims data, encounter data), segmentation or stratification methods that focus exclusively on this information do not meet the intent of this element, due to their potential to exacerbate health inequities.

Reports. The organization provides reports specifying the number of patients in each category and the programs or services for which they are eligible. Reports are a "point-in-time" snapshot during the look-back period.

Reports display data in raw numbers and as a percentage of the total enrolled patient population. The percentage may total more than 100% if patients fall into more than one category.

Factor 2: Assess methodology for bias

The organization describes its process for assessing its segmentation or stratification methodology for disparities (e.g., race, ethnicity, language or geographic area).

For example, if a segmentation/stratification method relies on utilization/ resource use or cost information (claims or encounter data reflecting an individual's past experience accessing health care or other services) as a proxy for current or future needs, it may systematically understate the needs of populations that have historically experienced lower rates of utilization due to barriers to accessing care. If this information is the exclusive or primary factor for targeting resources and interventions, these populations may be deprioritized for access to services or programs.

Methods that use systematically incomplete or unrepresentative data to build or train algorithms or other technological solutions to draw conclusions or make recommendations may also contribute to bias.

Note: *Although this factor requires the organization to have a process to assess its segmentation or stratification methodology for bias, NCQA does not evaluate the effectiveness or validity of the organization's process or methodology.*

Factor 3: Review segmentation

The organization reviews how interventions perform when applied to specific segments (e.g., engagement, utilization patterns, outcomes by segment) to determine if patients are matched to the appropriate level or type of intervention.

Findings are used to refine how patients are grouped or targeted over time.

Exceptions

None.

Examples

***Factor 1:* Segment or stratify entire population**

Example 1

Subset of Population	Targeted Intervention for Eligible Patients	Number of Patients	Percentage of Patients
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy case management	580	5%
Type 1 diabetes: Moderate risk	Diabetes management	2,320	20%
Tobacco use	Smoking cessation	580	5%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	1,160	10%

Example 2

Subset of Population	Targeted Interventions for Eligible Patients	Number of Patients	Percentage of Patients
Risk Tier 4	Intensive Complex care management: 10+ chronic conditions and comorbidities	2,400	7%
Risk Tier 3	Complex care management: 7-9 chronic conditions and comorbidities	2,800	8%
Risk Tier 2	Chronic Condition Management Program and 3-5 other comorbidities	1,800	5%
Risk Tier 1	Chronic Condition Management Program and 1-2 other comorbidities	8,800	24%
Risk Tier 0	Routine patient newsletters, no conditions	12,200	34%
No associated data	None	8,000	22%

Example 3

Risk Score of Population	Targeted Intervention for Eligible Patients	Number of Patients	Percentage of Patients
Score => 20 *(Terminal diagnosis with <6-month life expectancy)*	Palliative Care	1,000	2%
Score = >20 *(>20 risk factors, no terminal diagnosis)*	Complex care management	3,000	6%
Score = 15–19 *(15-19 risk factors)*	Chronic Condition Management with case manager; social worker referral	5,000	10%
Score = 10–14 *(10-14 risk factors)*	Chronic Condition Management with case manager; social worker referral	7,000	14%
Score = 7–9 *(7-9 risk factors)*	Condition Management app; social worker referral	9,000	18%
Score = 4–6 *(4-6 risk factors)*	Condition Management app	11,000	22%
Score = 1–3 *(1-3 risk factors)*	Prevention Education emails	7,000	14%
Score = 0 *(0 risk factors or no associated data)*	Routine patient newsletters	7,000	14%

Factor 2: Assess methodology for bias

Although NCQA does not prescribe minimum required components of a documented process for assessing for racial bias in the organization's segmentation/stratification methodology, examples of activities described by the documented process may include, but are not limited to:

- Asking questions the organization explores during its assessment (e.g., whether, where, when, how or why racial bias may exist in its methodology), including the organization's rationale for selecting the question.
- Assessing the methodology or approach, including the organization's rationale for selection (e.g., research, evidence, best practices).

- Creating a detailed plan for implementing the methodology or approach in the organization's policies and procedures (e.g., actions it will take, responsible roles, resources, timing, oversight, how it will act on findings).

NCQA does not prescribe methods for assessing for racial bias. Examples may include, but are not limited to:

- Inventory algorithms used by the organization for segmentation, risk stratification and resource allocation.
- A literature review to:

– Learn about the origins and results of racial bias in segmentation, risk stratification and resource allocation.

– Create an inventory of best practices and evidence-based methods for assessing racial bias.

- Evaluation of the completeness and representation (for lack of racial or ethnic diversity) of data sets used to build or train algorithms or other technological solutions that draw conclusions or make recommendations.
- A statement of the ideal predictive outcome (e.g., program or intervention eligibility, social or clinical needs) and assessment of whether variables/ measures/metrics used by the organization's segmentation or stratification method as a proxy for health status (e.g., utilization/resource use, cost) are equally predictive of the intended outcome across racial and ethnic groups.

Factor 3: **Review segmentation**

The organization reviews outcomes and engagement for a stratified high-risk diabetes population to assess if patients are matched to the appropriate interventions.

PHM 3: Complex Care Management

The organization coordinates services for its highest risk patients with complex conditions and helps them access needed resources.

Intent

The organization helps patients with multiple or complex conditions to obtain access to care and services and coordinates their care.

Element A: Access to Care Management

The organization demonstrates the following referral sources for complex care management:

1. **Medical management program.**
2. **Discharge planner.**
3. **Clinician.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews:

- The organization's policies and procedures.
- That the organization has multiple referral avenues in place throughout the look-back period.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The overall goal of complex care management is to help patients regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the patient's condition, determining available benefits and resources and developing and implementing a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex care management to be an opt-out program: All eligible patients have the right to participate or to decline to participate.

The organization offers a variety of programs to its patients and does not limit eligibility to one complex condition or to patients already enrolled in other organization's program.

Identification is how patients are segmented or stratified into the complex care management program using the process described in PHM 2, Element A. Patients are considered "identified" on the date when they are assigned to a segment or stratum.

The organization has a process for receive, route and act on referrals listed in the factors, even if it does not currently have access to the referral source. Multiple referral avenues can minimize the time between identifying a need and delivering services.

Factor 1: **Medical management program referral**

Medical management program referrals include those from other organization programs (e.g., disease management programs, health information lines, programs that identify needs for complex care management and are managed by the organization).

Factor 2: **Discharge planner referral**

Discharge planner referrals may be directed either to another organization's discharge planner or internal social worker. These referrals often include cases requiring acute care discharge planning, and the receiving organization must be equipped to accept referrals and act appropriately.

Factors 3: **Clinician referral**

The organization has referral options to other clinicians Referrals must be both clinical and socioeconomic to address both medical and nonmedical needs.

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from patients, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports from various sources on the number of patients identified for complex care management.
- Web-based materials with information about the complex care management program and referral instructions.

Element B: Care Management Process

The organization has written policies and procedures that describe how complex care management is performed and include the following high-level components:

1. **A comprehensive initial assessment.**
2. **An individualized care management plan.**
3. **Care coordination, referrals and follow-up.**
4. **Monitoring patient process and updating the plan.**

Scoring

Met	Partially Met	Not Met
The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review *For All Surveys*: NCQA reviews the organization's policies and procedures in place throughout the look-back period. NCQA may also review materials to demonstrate the completion of the assessment.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Comprehensive initial assessment**

The organization conducts a comprehensive initial assessment for patients to identify care management needs and inform individualized planning. The assessment includes the patient's:

- Clinical and behavioral health status.
- Relevant social and environmental factors.
- Functional and cognitive needs.
- Other needs (e.g., cultural, linguistic, communication, accessibility).
- Identified caregiver support or other available resources, when applicable.

***Factor 2:* Individualized care management plan**

The organization's policies and procedures describe how the organization develops and maintains an individualized care management plan that includes prioritized goals based on the patient's preferences. When appropriate, the plan includes support for patient self-management to promote engagement and sustained progress toward goals.

The organization identifies barriers to achieving goals, and outlines interventions, referrals and care coordination activities to address identified needs.

***Factor 3:* Care coordination, referrals and follow-up**

The organization's policies and procedures describe how care and services with clinicians, other organizations and community-based resources are coordinated, and how the organization maintains schedules for ongoing communication and regular follow-up with patients.

***Factor 4:* Monitoring patient process and updating the care plan**

The organization's policies and procedures describe how it regularly monitors patient progress against the care management plan and updates the plan when a patient's needs, goals, preferences or circumstances change. Updates must be documented and goals or resolutions must be tracked.

Exceptions

None.

Related Information

This element may be delegated to a vendor providing the care management services on behalf of the organization.

Examples None.

PHM 4: Self-Management Tools

The organization has evidence-based self-management tools available to help patients manage their health.

Intent

The organization provides self-management tools to help patients stay healthy and reduce risk.

Element A: Topics of Tools

The organization offers self-management tools, derived from available evidence, that provide patients with information on at least four of the following wellness and health promotion areas:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**
8. **An additional topic tailored to the organization's offerings.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-8 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's policies and procedures for developing evidence based self-management tools and the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screenshots, supplemented with documentation specifying the required features and functions of the site. If screenshots provided include detailed explanations of how the site works, the organization is not required to provide supplemental documents.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if no clients utilize the functions stated in the factors.

Self-management tools

Self-management tools help patients determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow patients to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that patients can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in self-management tools. If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

***Factor 8:* An additional topic**

The organization's tools address an additional topic of the organization's choice.

Exceptions

None.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.
- Glucose monitors.
- Blood pressure monitors.
- Peak flow monitors.
- Portion-size charts.
- Mobile health apps.
- Wearable devices.

***Factor 8:* Additional topic**

- Sleep habits.
- Social connection.
- Maternal health.

Coordinated Team-Based Care

CTC 1: Team-Based Care Strategy

The organization outlines its team-based care strategy to promote efficient, consistent, coordinated care.

Intent

The organization has a comprehensive plan for providing coordinated, team-based care for patients.

Element A: Care Strategy Description

The care strategy describes:

1. **The care team structure and roles.**
2. **The organization's processes for communication and coordination.**
3. **Non-organizational processes for communication and coordination.**
4. **The cross-training process for team members.**
5. **How patients/families/caregivers participate in care planning.**
6. **A culture of continuous improvement.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews a description of the organization's comprehensive team-based care strategy. The strategy may be fully described in one document, or the organization may provide a summary document with references or links to supporting documents.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Care team structure and roles**

A **care team** is a defined, multidisciplinary group of clinical and non-clinical individuals who are collectively responsible for planning, delivering, coordinating and continuously improving care for a patient population. The care team operates under clearly defined roles, communication processes and accountability structures, and partners with patients, families and caregivers to support shared decision making and continuity of care across settings.

The organization provides an overview of staff and outlines duties that staff perform. The organization defines who participates in staff huddles (e.g., clinicians, care coordinators, support staff), and evaluates whether the organization has sufficient staff for each specialty.

Factor 2: **Organizational communication and coordination processes**

The organization describes:

- Its processes for clinical decision making, coordination and communication of patient care needs.
  - This may include scheduled huddles to review patients with complex needs, care gaps, preventive protocols and urgent issues.
- Its processes for providing continuity of care outside traditional methods or scheduling.

Factor 3: **Non-organizational communication and coordination processes**

The organization describes its processes for communicating patient care needs with external entities (e.g., other care partners).

Factor 4: **Cross training processes for team members**

The organization describes on-boarding and annual training procedures for new and existing staff, and determines:

- Required clinical and nonclinical topics.
- Training frequency.

Factor 5: **Patient/family/caregiver participation in care planning**

The organization describes how patients, their families and caregivers are involved in the development and review of care plans through synchronous and asynchronous methods. Participation promotes shared decision making and improves adherence to treatment.

Factor 6: **Culture of continuous improvement**

The organization outlines its procedure for regular review of processes and outcomes using data-driven insights, fostering open feedback loops among team members and patients and applying quality improvement frameworks such as PDSA cycles.

Exceptions

None.

Examples

Factors 1–3: **Care team structure and coordination processes**

- An organization chart with defined roles. Examples of process assignments may include, but are not limited to:
  - Care management/continuity of care:
    - Who has authority to obtain consents, initiate visits and establish themselves as primary provider in the care plan.
    - Who maintains comprehensive care plan.
    - Who has authority to document communications in the care plan.
    - The escalation process.
- Communication methods may include 24/7 answering services, on-call triage process or conducting home-visits.

- Referrals:
  - Whether there is a referral team, and who has authority to make referrals.
  - Who composes the clinical question to the consultant or specialist.
  - Who sends referrals, and how.
  - Who determines which relevant patient demographic, clinical data and test results to include, and how they are provided.
  - Who documents the referral and handles requests for additional information.
  - Who handles the response and incorporates it into the care plan.
  - Who is responsible for monitoring to ensure responses are received.

Factor 4: **Cross training**

- Lunch-and-learn training, with participant log.
- E-learning, with completion of documentation.

Factor 5: **Patient/family/caregiver participation**

- Communication methods used (e.g., office visits, secure messaging, patient portal, virtual services).
- Consideration for geographic, transportation, language or scheduling needs, if appropriate.
- Information provided to caregivers and families.
- The clinical record documents that goals were discussed with the patient/family/caregiver, and next steps were acknowledged in the care plan.

Factor 6: **Continuous Improvement**

- A process for meetings between the organization and its quality improvement committee, including the proposed agenda and a discussion of performance data, identification of improvement opportunities, action plans and follow-up.
- Regular team huddles, feedback loops, review of performance metrics, innovation in care delivery and/or dissemination of best practices internal or external to the organization.

CTC 2: Care Coordination

The organization optimizes care coordination processes to minimize gaps in care.

Intent

The organization has a process for closing the loop on patient referrals and preventive services to ensure timely and appropriate care.

Element A: Referral Management

The organization has a process for managing referrals that includes:

1. **Defining when referrals are needed.**
2. **Providing the consultant or specialist with the clinical question, the required timing, the type of referral and relevant patient data.**
3. **Identifying the appropriate follow-up time.**
4. **Tracking referrals to close the loop.**
5. **Documenting consultant or specialist results or recommendations in the patient's clinical record.**

Scoring

Met	Partially Met	Not Met
The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews:

- *For factors 1–5:* The organization's policies and procedures for managing referrals.
- *For factor 4:* Materials as evidence of tracking referrals.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The organization uses the patient's medical health history and clinical protocols to determine when referrals are needed. Referrals and services may be tracked by the organization using an electronic system, if determined by the clinical team to be important to a patient's treatment or as indicated by practice guidelines.

The organization confirms that referral services are within geographical or virtual access for the patient and if the referral is in the patient's network.

***Factor 1:* Process for needed referrals**

The organization has a documented process for determining when referrals are needed to maintain timely, appropriate and coordinated care. The process includes:

- Criteria for determining when referral is necessary.

- How information is shared with the receiving provider and the patient.

Factor 2: **Providing relevant patient data and referral information**

The organization's process outlines how the referring clinician provides:

- A reason for the referral.
  - This may be stated as a clinical question to be answered by the specialist.
- The type of referral.
  - This 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 urgency of the referral, including the reason for an urgent appointment.
- Relevant patient demographic data, clinical information and information needed for the care plan.

Factor 3: **Identifying appropriate follow-up time**

The organization defines time frames for all referrals.

Factor 4: **Tracking referrals to close the loop**

The organization has a tracking process that includes when the referral or preventive service was initiated, and the timing indicated for receiving reports.

Although closing the loop does not require confirmation that the patient received the referred service, the organization tracks whether the patient was able to access the referral, and documents follow-up communication within the specified time frame, outcomes or next steps. The organization will not lose points for patient non-adherence or specialist non-responsiveness.

Factor 5: **Documenting specialist or consultant recommendations**

If the patient receives referral services, the organization documents the specialist or consultants' recommendations in the clinical record. The organization updates the care plan as needed. If the specialist does not send a report, the organization contacts the specialist organization and documents its efforts to retrieve the report. The organization continues attempting to retrieve the report so the loop can be closed.

Exceptions

None.

Examples None.

Element B: Transitions of Care

To facilitate safe transitions of care, the organization:

1. **Identifies discharged patients.**
2. **Conducts post-discharge outreach.**
3. **Reviews discharge information and document next steps or updates in the care plan.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review NCQA reviews the organization's documented process in place for factors 1–5.

For factor 2: NCQA reviews the organization's materials demonstrating post-discharge outreach.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

A **care transition** is movement of individuals between care settings as condition and care needs change during the course of a chronic or acute illness. Individuals moving between settings are particularly vulnerable to receiving fragmented and unsafe care if transitions are poorly coordinated.

A **care setting** is a provider or place that delivers health care and health-related services, and includes:

- Urgent care facilities.
- In-patient facilities.
- Emergency departments.
- Skilled nursing facilities.
- Rehabilitation facilities.

The **receiving setting** is the setting responsible for care after a transition.

Primary care plays a critical role in facilitating continuity, safety and coordination during transitions by identifying patients who move across care settings, engaging them in timely follow-up and reviewing discharge information to clarify next steps. Effective transition processes help reduce gaps in care, prevent avoidable readmissions and help ensure that care plans remain accurate, up to date and aligned with the patient's needs and preferences.

The organization must manage care transitions for the entire primary care patient population that needs care transitions. If the organization does not manage care transitions for all individuals who receive services, the documented process describes the population for which the organization manages transitions.

The organization uses the patient's electronic medical record or other protocols to determine when a patient has received in-patient services.

Planned transitions include elective surgery or a decision to enter a long-term care facility. **Unplanned transitions** include sudden hospitalizations resulting from emergencies.

Factor 1: **Identify discharged patients**

The organization's policies and procedures specify a process for identifying individuals who transitioned back to primary care. Because individuals may transition between types of settings, the process addresses transitions that affect delivery of services provided by the organization.

Factors 2: **Conduct post-discharge outreach**

The organization has a process for initiating contact for follow-up with patients who transition back to primary care. The organization indicates the type of communication method it uses to contact patients (includes telehealth or other virtual communication methods), and documents when contact attempts are unsuccessful.

The organization may demonstrate how it conducts post-discharge outreach through materials.

Factor 3: **Review of discharge information and care plan updates**

The organization describes how it reviews discharge information, care plan updates and next steps with the patient (and their caregivers, if applicable). The review process includes establishing a time frame for required face-to-face visits, medication reconciliation/management and required differences in planning based on the complexity of medical problems or risk of complications. The organization communicates changes or updates to the care plans to the patient or caregiver.

Exceptions

None.

Examples None.

Element C: Reporting on Readmissions

The organization reports patient's readmission data by:

1. **Collecting and assessing the 30-day readmission rate.**
2. **Collecting and assessing the readmission avoidance rate.**
3. **Identifying at least one opportunity to improve.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review *For All Surveys*: NCQA reviews reports that demonstrate the collection and assessment of readmission rate indicators.

Look-back period *For All Surveys:* 6 months.

Explanation The organization collects and evaluates readmission rates by applying the formulas for each factor below. The organization's assessment for factors 1 and 2 includes interpreting results, identifying trends or areas of concern and determining potential underlying causes for observed readmission patterns.

***Factor 1:* 30-day readmission rate**

The percentage of patients attributed to the organization who are readmitted within 30 days of discharge.

The organization uses the following formula:

Readmission rate = (Total number of patients readmitted within 30 days/ Total discharges) * 100

***Factor 2:* Readmission avoidance rate**

The percentage of patients attributed to the organization identified as high-risk who did not experience readmission within 30 days.

The organization uses the following formula:

Avoidance rate = (Total number of admitted patients NOT readmitted within 30 days/Total number of high-risk patients discharged) * 100

***Factor 3:* Identify opportunity to improve**

Based on the results of the assessment of factors 1 and 2, the organization identifies at least one recommendation for quality improvement.

Exceptions

None.

Examples

***Factor 1:* 30-day readmission rate**

Riverside Primary Care Group reviews all hospital discharges for attributed patients each month.

In one month:

- 240 patients were discharged.
- 36 patients were readmitted within 30 days.

Readmission rate = (36 ÷ 240) × 100 = 15%

The care coordination team compares this rate to rates from prior months. The 15% rate is a 3 percentage point increase from the previous quarter.

Heart failure and COPD patients account for almost half of readmissions, but represent only 20% of total discharges.

The team investigates contributing factors (e.g., medication adherence, follow-up visit timeliness, home-based care needs.

***Factor 2:* Readmission avoidance rate**

Riverside Primary Care Group also tracks high-risk patients, using its internal risk-stratification algorithms and discharge data.

In the same reporting month:

- 72 high-risk patients were discharged.
- 54 high risk patients were not readmitted within 30 days.

Avoidance rate = (54 ÷ 72) × 100 = 75%

One in four high-risk patients is being readmitted, indicating a need for targeted interventions. Many high-risk patients had follow-up appointments scheduled more than 10 days post-discharge, which may be too late for optimal stabilization.

***Factor 3:* Identify opportunity to improve**

Based on the assessment of factors 1 and 2, the care team identifies the following improvement opportunity: Implement a structured 3-day and 7-day post-discharge follow-up protocol for high-risk patients.

Rationale:

- Patients who received follow-up within 7 days had a significantly lower readmission rate (12%) compared to those seen after 7 days (22%). Heart failure and COPD patients often required medication adjustments or equipment support soon after discharge—issues that were missed when follow-up was delayed.

Action steps:

- Assign care coordinators to call all high-risk patients within 48 hours of discharge.
- Prioritize in-person or telehealth visits within 3–5 days.

- Provide medication reconciliation and ensure patients understand discharge instructions.
- Add automated reminders in the EMR to flag high-risk discharges daily.

Expected impact:

- An overall reduction in readmissions by 2–3 percentage points in the next quarter and an improved high-risk avoidance rate from 75% to at least 85%.

Element D: Reporting on Acute Care Utilization

The organization reports on patient's acute care utilization by:

1. **Collecting and assessing the ED visit rate.**
2. **Collecting and assessing the hospital admissions rate.**
3. **Identifying at least one opportunity to improve.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review *For All Surveys*: NCQA reviews reports that demonstrate collection and assessment of utilization indicators.

The organization is scored Met if it submits evidence for factors 1–3.

Note: *NCQA does not score evidence quality for this element.*

The organization is scored Not Met if it does not submit evidence for this element.

Look-back period *For All Surveys:* 6 months.

Explanation The organization collects and evaluates utilization rates by applying the formulas for each factor below. The organization's assessment for factors 1 and 2 includes interpreting results, identifying trends or areas of concern and determining potential underlying causes for observed patterns.

Factor 1: **ED visits**

The number of patients attributed to the organization who have visited the ED per 1,000 attributed patients.

The organization uses the following formula:

ED visit rate = (Total ED visits/
Total attributed patient population) * 1,000

Factor 2: **Hospital admissions rate**

The number of acute, unplanned inpatient admissions per 1,000 attributed patients.

The organization uses the following formula:

Admission rate = (Total number of acute inpatient admissions/ Total number of attributed patients) *1,000

Factor 3: **Identify opportunity to improve**

Based on the results of the assessment of factors 1 and 2, the organization identifies at least one recommendation for quality improvement.

Exceptions

None.

Related information

This element has no points. If an organization does not submit evidence for this element, resulting in a score of Not Met, the score does not impact the organization's overall score or performance.

Examples

Factor 1: **ED visits**

Riverside Primary Care Group reviews ED utilization for all attributed patients on a quarterly basis.

In one quarter:

- 5,200 patients were discharged.
- 780 patients were readmitted within 30 days.

ED visit rate = (780 ÷ 5,200) × 1,000 = 150 ED visits per 1,000 patients

The care coordination team compares this rate to rates from prior months and identifies an upward trend from 120 to 150 ED visits per 1,000 patients.

Patients with unmanaged chronic conditions (e.g., diabetes and asthma) account for a disproportionate share of ED visits.

The team investigates contributing factors (e.g., medication adherence, follow-up visit timeliness, home-based care needs).

Factor 2: **Hospital admissions rate**

Riverside Primary Care Group also tracks acute, unplanned inpatient admissions among attributed patients.

In the same reporting quarter:

- 5,200 high-risk patients were discharged.
- 156 high risk patients were not readmitted within 30 days.

Admission rate = (156 ÷ 5,200) × 1,000 = 30 admissions per 1,000 patients

This reflects an increase from 26 admissions per 1,000 patients in the previous quarter. A significant portion of admissions is related to conditions that may be preventable with earlier interventions, including complications from hypertension and heart failure.

Further review shows that many admitted patients had not had a recent primary care visit.

Factor 3: Identify opportunity to improve

Based on the assessment of factors 1 and 2, the care team identifies the following improvement opportunity: Implement expanded access and proactive care management for high-risk patients.

Rationale:

- Patients without recent primary care engagement are more likely to utilize ED services and experience avoidable admissions. A subset of high-risk patients is driving a disproportionate share of utilization. Earlier intervention and improved access could reduce avoidable acute care use.

Action steps:

- Expand urgent and after-hours appointment availability.
- Use risk stratification to identify high-utilization patients and enroll them in a care management program.
- Conduct proactive outreach to patients who have not had a recent primary care visit.
- Implement alerts in EHR for recent ED visits or hospital discharges.

Expected impact:

- An overall reduction in ED visits over the next two quarters and a decrease in admissions per 1,000 patients, particularly among high-risk populations.

CTC 3: Staff Culture and Experience

The organization assesses staff experience to support a quality-driven environment.

Intent

The organization assesses the clinical environment to monitor and improve activities that support engagement, well-being and quality care.

Element A: Assessment of Staff Experience

The organization evaluates staff experience delivering care by using a structured tool that covers the following domains:

1. **Team structure and collaboration.**
2. **Engagement and satisfaction.**
3. **Psychological safety and well-being.**
4. **Resources and support.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Materials, Reports

Scope of review *For All Surveys*: NCQA reviews reports or materials as evidence of measuring staff experience and evaluation findings.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The organization uses a structured tool to evaluate clinician experience (e.g., survey).

Factor 1: **Team structure and collaboration**

The organization asks its staff about their perception on whether the staffing model promotes effective collaboration for delivering team-based primary care. The organization may evaluate the perception of shared values, clearly defined roles, effective communication and team dynamics.

Factor 2: **Engagement and satisfaction**

The organization evaluates the level of staff engagement in patient care.

Factor 3: **Psychological safety and well-being**

The organization evaluates the ability of staff to take interpersonal risks (e.g., speaking up about mistakes or concerns) without fear of punishment. The organization may also assess the overall state of health and well-being and sense of burnout.

Factor 4: **Resources and support**

The organization evaluates whether staff has the necessary resources and support to deliver care effectively. This includes evaluating availability and assigning adequate support staff to manage patient panels, as well as access to appropriate tools, technology and other essential resources.

Exceptions

None.

Examples None.

Element B: Care Team Burnout Monitoring and Mitigation

The organization has an approach to annually monitor and mitigate care team burnout that includes:

1. **Measurement of care team burnout.**
2. **Evaluation of results.**
3. **Resources for clinical staff.**
4. **Integration into organizational quality improvement.**
5. **Promotion of transparency and feedback.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews:

- *For factor 1:* The organization's documented process for measurement of burnout.
- *For factors 1–5:* Reports or materials as evidence of measuring burnout, resources provided to staff, evaluation of results and findings and notification of results to clinicians.

Look-back period *For All Surveys:* At least once during the prior year.

Explanation **Care team burnout** is characterized by emotional exhaustion, depersonalization or cynicism toward patients and a reduced sense of professional accomplishment arising from chronic organizational and job-related stress.

***Factor 1: M*easurement of care team burnout**

The organization has a process for annually measuring care team burnout, at a minimum, using one of the following validated tools:

- The Maslach Burnout Inventory.
- The Stanford Professional Fulfillment Index.
- Mini-Z Worklife and Burnout Reduction Instrument.

The organization documents the frequency of survey administration, and identifies staff who are surveyed.

Factor 2: **Evaluation of results**

The organization evaluates results from Element A and Element B, factor 1.

The evaluation includes a summary of survey results, and highlights key findings.

Factor 3: **Integration into organizational quality improvement**

The organization uses findings from factor 2 to adjust staffing models, workflows and technology use.

Factor 4: **Resources for clinical staff**

The organization provides resources for staff who exhibit signs of burnout.

Factor 5: **Promoting transparency and feedback**

The organization shares aggregated results with clinicians, and demonstrates that timely actions are taken based on survey findings.

Exceptions

None.

Examples

Factor 1: **Annual measurement of care team burnout**

ABC Clinic administers the Maslach Burnout Inventory survey semiannually to all clinicians, including physicians, nurses and medical assistants. Survey participation is anonymous, and is conducted via a secure online platform.

The organization documents the survey schedule in its Workforce Well-Being policy, and maintains a list of clinician roles included in the survey.

Factor 2: **Evaluation of results**

The organization reviews survey responses and prepares a summary report. Results are compared with feedback from Element A to identify overlapping issues.

Key findings include:

- 25% of clinicians report high stress levels (burnout prevalence).
- Long patient schedules and lack of time for documentation are top concerns.

Factor 3: **Integration into organizational quality improvement**

Based on findings, the clinic implements changes:

- Reduces the daily patient load per provider from 24 to 20.

- Allocates protected time for documentation at the end of each day.
    - Introduces a shared medical assistant model to reduce administrative burden.

Factor 4: **Resources for clinical staff**

The clinic offers:

- Flexible scheduling (e.g., 1 telehealth day per month).
- Access to counseling through a local mental health provider at a discounted rate.
- Monthly wellness sessions (e.g., mindfulness and stress management workshops).

Factor 5: **Promoting transparency and feedback**

- Aggregated survey results are shared during the quarterly staff meeting.
- The clinic manager explains actions taken, and invites feedback.
- Updates are posted on the clinic's internal bulletin board for visibility.

CTC 4: Alternative Payment Arrangements

The organization aims to move beyond traditional fee-for-service models by promoting risk-sharing, transparency and reinvestment.

Intent

The organization supports the sustainability and effectiveness of value-based care through alternative payment models.

Element A: Alternative Payment Arrangement Participation

The organization demonstrates their participation in a value-based agreement including:

1. **Upside gainsharing participation.**
2. **Downside risk participation**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Materials

Scope of review *For All Surveys*: NCQA reviews the organization's value-based agreement.

Look-back period *For All Surveys*: Prior to the survey date.

Explanation

Factors 1, 2

The organization demonstrates that it participates in an alternative payment arrangement by providing information about its participation or a copy of an executed agreement of an upside gainsharing (one-sided) or downside risk (two-sided) arranged model.

Exceptions

None.

Examples

Upside gainsharing (one-sided) risk models

- *Pay-for-performance:* Clinicians earn bonuses for achieving quality benchmarks.
- *Shared savings:* The organization shares in savings generated by reducing the total cost of care below a benchmark, without financial penalties for overspending.
- *Other quality incentive programs:* Additional payments are tied to achieving specific clinical outcomes or process improvements.

Downside risk (two-sided) risk models

- *Shared savings and losses:* The organization shares in savings when costs are below target, but also shares in losses if costs exceed benchmarks.
- *Capitation with quality adjustments:* Fixed per-member-per-month payments, with upside and downside adjustments based on quality utilization metrics.
- *ACO risk contracts:* Full or partial risk adjustments where providers are accountable for both cost and quality outcomes.

Element B: Risk Absorption Capacity

The organization describes how financial risk is managed, including:

1. Identifying staff who are accountable for alternative payment financial performance.

2. How underperformance is reviewed and acted on.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Materials

Scope of review *For All Surveys*: NCQA reviews the organization's materials for factors 1 and 2.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation ***Factor 1:* Identifying staff accountable for APM performance**

The organization identifies staff who are accountable for managing and delivering financial performance under alternative payment arrangements (including arrangements with upside gainsharing). Accountability includes clear ownership of results, defined roles and responsibilities and decision authority to take corrective action when performance is off target.

The organization demonstrates:

- Accountable roles or bodies responsible for performance (named leadership roles, designated committee, a governance structure).
- What each accountable party oversees (total cost of care performance, utilization trends, quality performance affecting shared savings/losses, risk adjustment or attribution issues, contract performance monitoring).
- How accountability is operationalized, including how performance information is delivered to accountable parties (e.g., dashboards, recurring reports) and how responsibilities are coordinated across clinical leadership, operations, analytics/finance and care management functions.

- Decision rights (who can authorize interventions, workflow changes, resource allocation, escalation to leadership, contract-level remediation activities).

Factor 2: **How underperformance is reviewed and acted on**

The organization demonstrates how it identifies underperformance in alternative payment arrangements and addresses performance gaps in cost, utilization, quality or other contract-linked performance measures.

The organization shows:

- How underperformance is detected, including performance indicators monitored (e.g., cost, utilization, quality measures tied to contract performance) and the frequency of monitoring and review (e.g., monthly, quarterly, other defined cadence).
- How performance is reviewed, including forum where results are reviewed (e.g., designated meetings, committees, operational huddles) and how data are interpreted to determine root causes or drivers of underperformance.
- How actions are selected and implemented, including operational mechanisms the organization uses when results are off target (care management workflow changes, practice transformation supports, utilization management interventions, targeted outreach, documentation/ coding improvement, referral management changes, other performance improvement activities).
- Escalation paths and triggers describing how the organization decides when to escalate issues (e.g., thresholds for downside exposure, persistent negative performance trends, material variance from targets), and who is notified/engaged at each escalation level.
- Follow-through and feedback loop describing how the organization tracks whether actions were completed and performance improved (e.g., action logs, follow-up reviews, documented decisions to continue/adjust interventions).

Exceptions

None.

Examples

Factor 2: **How underperformance is reviewed and acted on**

- Meeting materials/minutes showing review and decisions.
- Dashboards with defined thresholds.
- Issue logs.
- Corrective action plans.
- Performance improvement workplans.
- Escalation protocols.
- Documentation showing interventions were launched in response to off-target performance.

Element C: Primary Care Reinvestment for Risk-Critical Capabilities

The organization demonstrates its approach to reinvesting earnings from alternative payment arrangements involving primary care to support internal capabilities including:

1. **Total value-based payment revenue attributable to primary care.**
2. **Reinvestment of value-based payment earnings to internalize risk-critical capabilities.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review *For All Surveys*: NCQA reviews:

- *For factor 1*: The organization's documented methodology and supporting documentation used to estimate total value-based payment revenue attributable to primary care for the measurement period.
- *For factor 2*: Materials as evidence of how the organization allocates and uses value-based payment revenue to support internal value-based infrastructure/programs and associated workflows.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Total value-based payment revenue attributable to primary care**

The organization reports an estimated amount of total value-based payment revenue attributable to primary care for the measurement period, and describes the methodology and assumptions used to develop the estimate. The estimate must include all value-based payments received by or on behalf of the organization for arrangements involving primary care during the measurement period (consistent with the organization's documented methodology).

***Factor 2:* Reinvestment of value-based payment revenue to internalize risk-critical capabilities**

The organization demonstrates how value-based payment incentives are reinvested to build internal capabilities required to manage value-based performance, including, as applicable, cost/utilization analytics, value-based payment performance monitoring, care management infrastructure and practice transformation/performance improvement support.

Value-based payment revenue attributable to primary care is the portion of value-based payments the organization can reasonably associate with primary care accountability for a defined population during the measurement period, using a documented method that is traceable to source documentation (e.g., payer settlement reports, contracting terms, internal finance reporting,

analytics). NCQA does not require a single attribution method; the organization must describe its method and assumptions.

Exceptions

None.

Examples

***Factor 1:* Total value-based payment revenue attributable to primary care**

Evergreen Primary Care Network participates in multiple alternative payment arrangements, including shared savings and population-based payments. For the most recent performance year, Evergreen estimated its total value-based payment revenue attributable to primary care by aggregating:

- $425,000 in shared savings incentives from two commercial ACO partners.
- $180,000 in quality-based incentive payments tied to preventive care, chronic disease management and patient-reported experience measures.
- $95,000 in care coordination payments for patient navigation and risk-stratified outreach.

The finance team leveraged payer settlement reports, internal financial statements and contract documentation to substantiate the estimate. The methodology for attribution was documented and approved by finance leadership.

***Factor 2:* Reinvestment of value-based payment revenue to internalize risk-critical capabilities**

- *Operating expenses:* Costs directly tied to value-based care program delivery.
- *Staffing:* Salaries and wages for care coordinators, population health managers and related roles.
- *Technology and IT equipment:* Tools for data analytics, care navigation and patient engagement.
- *Training and education:* Programs for clinicians and staff on value-based care workflows and best practices.
- *Administrative support:* Resources for reporting, compliance and performance tracking.
- *Care programs:* Initiatives focused on chronic disease management, preventive care and patient engagement.
- *Population health:* Investments in analytics, outreach and risk stratification.
- *Care navigation services:* Enhancing patient access and coordination across the continuum of care.

Evidence of infrastructure and program investments may include, but are not limited to:

- Financial records or budget reports.
- Purchase orders or contracts for IT systems (analytics platforms, care navigation tools).

- Training programs for clinicians and staff, population health initiatives or care management programs.

Patient Safety and Experience

PSE 1: Access to Services

The organization focuses on achieving comprehensive person-centered care through a technology-supported approach that prioritizes accessible services.

Intent

The organization provides timely access to care through various methods.

Element A: Access to Care Team

The organization provides 24/7 access to a provider or care team.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Materials, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's performance through a "demo" or "test" log-on ID to patient portal. If the organization cannot provide a demo or test log-on, NCQA reviews materials (e.g., screenshots) or reports demonstrating the organization's electronic system for two-way communication.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The organization provides patients with 24/7 access to their care team or provider through multiple channels, including, but not limited to, a secure interactive electronic system that allows two-way communication between the organization and patients/families/caregivers, telephone or other digital means, as well as alternative care delivery options beyond in-person office visits to support timely and continuous care. This includes on-call staff for urgent needs, home visits and expanded or after-hours protocols to accommodate patient needs.

Exceptions

None.

Examples River Valley Community Health Center implemented a multi-modal system that helps patients reach their care team 24/7. This round-the-clock access uses multiple communication channels:

- A 24/7 nurse triage line to:
  - Provide real-time clinical advice.
  - Assess symptoms.
  - Contact the on-call provider for situations needing escalation.
  - Document encounters directly in the EHR for next-day care team review.

- On-call provider support.
  - Each evening, a primary care provider rotates as the on-call clinician to respond to urgent escalations from the triage line or via the patient portal.
- Secure online portal allowing for two-way messaging.
  - Patients can message their care team for clinical questions, request prescription refills or send photos of symptoms. Complex portal messages automatically route to clinical staff for review.
- Timely alternative care options.
  - The health center offers care beyond in-office visits:
    - Telehealth video visits for same-day or next-day non-urgent concerns.
    - Home visits for patients with mobility limitations or chronic care needs.
    - After-hours care block from 5–8 p.m. twice per week for working families.
    - Remote monitoring support for high-risk patients (e.g., hypertension, diabetes).

Interactive electronic systems may include, but are not limited to:

- An online website.
- Patient portal.
- Secure email system.

Element B: Enhanced Communication Opportunities

The organization offers enhanced communication opportunities that allow patients to initiate digital interactions requiring clinical decision making, including:

1. **Digital appointment scheduling tools.**
2. **Automated appointment reminders.**
3. **Virtual check-in for appointments.**
4. **Virtual clinical assessments or consultations.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews the organization's policies and procedures and materials demonstrating factors 1–2.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Digital appointment scheduling tools**

The organization provides digital appointment scheduling tools that allow patients to request, schedule and confirm appointments electronically. These tools may support both in-person and telehealth visits.

***Factor 2:* Automated appointment reminders**

The organization uses automated appointment reminders to notify patients of upcoming visits. Reminders are delivered through digital (e.g., text message, email, patient portal notifications), and may include visit date and time, visit type and instructions.

***Factor 3:* Virtual check-in for appointments**

The organization offers virtual check-in functionality that allows patients to complete pre-visit activities electronically before an appointment. Virtual check-in may include confirming demographic information, acknowledging consent or submitting symptoms or concerns.

***Factor 4:* Virtual clinical assessments or consultations**

The organization enables virtual clinical assessments or consultations that allow patients to receive clinical decisions without requiring an in-person visit, when appropriate. Interactions may be synchronous or asynchronous, and are provided by a licensed member of the care team.

Exceptions

None.

Examples None.

Element C: Demonstrating Appointment Availability

The organization demonstrates appointment availability by calculating and analyzing the average turnaround time for the following appointments:

1. **Routine visits for established patients.**
2. **Urgent visit for established patients.**
3. **Routine visits for new patients.**
4. **Urgent visits for new patients.**
5. **Transitional care management or post-discharge visit for all patients.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organizations meets 2-3 factors	The organization meets 0-1 factors

Data source Reports

Scope of review *For All Surveys:* NCQA reviews reports that calculate appointment availability indicators.

Look-back period

For All Surveys: Prior to the survey date.

Explanation

The **average turnaround time for appointments** is the average number of business days between the date a patient requests an appointment and the actual appointment date.

Factors 1–5

The organization conducts quantitative analysis of the average turnaround time for the following appointments:

- *Routine visits for established patients:* Scheduled, non-urgent visits for patients who are actively empaneled to the organization.
- *Urgent visits for established patients:* Time-sensitive visits for patients who are actively empaneled to the organization.
- *Routine visits for new patients:* Scheduled, non-urgent visits for individuals who are establishing care with the organization for the first time.
- *Urgent visits for new patients:* Time-sensitive visits for individuals who are new to the organization and require prompt clinical evaluation for an acute concern.
- *Transitional care management or post-discharge visits for all patients:* Visits focused on supporting patients following a transition from an inpatient setting (e.g., hospital, ED, skilled nursing) to primary care.

The organization conducts qualitative analysis if quantitative analysis demonstrates the following goals were or were not met:

- Routine appointments for new and established patients 20-25 business days.
- Urgent appointments for new and established patients: 1-2 business days.
- Transitional care management visits for all patients: 5-10 business days.

The organization uses the following formula in the quantitative analysis:

$$\text{Average turnaround time} = \sum (\text{Appointment date} - \text{request date}) / (\text{total appointments})$$

Exceptions

None.

Examples

None.

PSE 2: Medication Management

The organization collects medication and prescribing data to identify patterns and improve health outcomes in patients.

Intent

The organization assesses medication reconciliation procedures to ensure consistent practice and safe care.

Element A: Medication Reconciliation

The organization completes medication reconciliation for all active empaneled patients at every care transition, or at least annually, by reviewing and documenting all medications a patient is taking, with corrective actions for identified gaps.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's process for medication reconciliation, reviews evidence of completed medication reconciliation (reports) for all empaneled patients and reviews the organization's corrective action plan for identified gaps if medication reconciliation is not completed for every empaneled patient.

Look-back period *For All Surveys:* 12 months.

Explanation

Medication reconciliation is obtaining and maintaining an accurate list of all medications (prescription and non-prescription medications and supplements) a patient is taking, and addressing potential conflicts including name, dosage, frequency and drug-drug interactions. The organization completes medication reconciliation for all active empaneled patients at least annually or at care transitions, and documents corrective actions for identified gaps.

An **active primary care patient** is an individual who has seen their primary care provider within the last 12–24 months, indicating an ongoing, established relationship.

Exceptions

None.

Examples None.

Element B: Medication Response and Adherence

The organization has a process for assessing and addressing patient response to medication and barriers to medication adherence that includes:

1. **Communicating with patients to identify and address barriers to medication adherence.**
2. **Systematically obtaining prescription claims or pharmacy records to keep medication lists up to date.**
3. **Clinical measurement or monitoring.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *For All Surveys*: NCQA reviews the organization's process for communicating with patients to address barriers to medication adherence, obtaining prescription claims or pharmacy records and clinical measurement or monitoring.

Look-back period *For All Surveys:* 12 months.

Explanation

***Factor 1:* Communicating with patients**

The organization has a process for communicating with active empaneled patients, and documents barriers to medication adherence. At a minimum, during a patient survey or encounter, the organization asks patients if they are:

- Having difficulty taking medication.
- Having difficulty affording medication.
- Experiencing side effects.
- Taking medication as prescribed (asked at all visits).
- Not taking medication as prescribed.

If a patient answers "yes," the organization documents the patient's responses.

***Factor 2:* Obtaining prescription claims or pharmacy records**

The organization has a process for obtaining prescription claims data or other medication transaction history that includes, but is not limited to:

- Surescripts e-prescribing network.
- Regional or state health information exchanges.
- Insurers.
- Prescription benefit management companies.

Factor 3: **Clinical measurement or monitoring**

The organization has a process to determine if a patient is not adhering to medication when clinically indicated, using direct clinical results through methods such as biochemical assays or therapeutic drug monitoring.

The organization may also rely on indirect evidence or clinical monitoring if a patient is not meeting monitoring goals.

Exceptions

None.

Examples

Factor 1: **Communicating with patients**

Barriers to adherence (e.g., not understanding directions, confusion with multiple medication regimens) lead to poorer health outcomes and compromise patient safety.

Using patient-centered communication and active listening to assist providers in understanding the underlying cause and problem solve with the patient. Examples of lack of adherence may include:

- Concern about side effects.
- Financial barriers.
- Lack of understanding.
- Complex treatment plans.
- Absence of symptoms.

Element C: Prescribing Patterns

The organization monitors and analyzes prescribing patterns by:

1. **Monitoring all prescribed medications.**
2. **Evaluating trends or patterns in providers' prescribing history.**
3. **Acting based on analysis results from factor 2.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For All Surveys:* NCQA reviews the organization's process and evidence of monitoring and analyzing prescribing patterns and taking action based on results.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Monitoring medications**

The organization has a process for tracking prescribed all medications, including, but not limited to:

- Antibiotics.
- Opioids.
- Steroids.
- Benzodiazepines.
- Medications with a narrow therapeutic window or high risk of side effects.
- Anticoagulants.
- Antidiabetic agents.

***Factor 2:* Evaluating trends or patterns**

The organization evaluates trends or patterns in provider's prescribing patterns and documents its findings.

***Factor 3:* Taking action**

Based on the results from factor 2, the organization takes action to improve at least one finding.

Exceptions

None.

Examples

***Factors 1*: Tracking medications**

An EHR alert system to flag high-risk medications, including antibiotics, opioids and anticoagulants when prescribed.

***Factor 2:* Evaluating trends**

Quarterly data analysis revealed that 35% of URI visits resulted in an antibiotic prescription, exceeding national benchmarks.

***Factor 3:* Taking action**

- Develop provider education sessions on evidence-based prescribing.
- Introduce clinical decision support tools in the EHR to guide appropriate antibiotic use.
- Share provider prescribing reports during performance reviews.

PSE 3: Patient-Centered Experience

To support a quality-driven environment, the organization assesses patient experience.

Intent

The organization assesses patient experience to monitor and improve activities that support engagement, well-being and quality care.

Element A: Assessment of Patient Experience

The organization evaluates patient, family or caregiver experience by conducting a survey and reporting the response rate. The organization may use an existing standardized method (paper or electronic) or a homegrown tool that covers the following dimensions:

1. **Access to clinical care.**
2. **Communication.**
3. **Continuity.**
4. **Coordination.**
5. **Education and information.**
6. **Patient engagement.**
7. **Respect for preferences.**
8. **Whole-person care.**

Scoring

Met	Partially Met	Not Met
The organization meets 6-8 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source Materials, Reports

Scope of review *For All Surveys:* NCQA reviews materials that demonstrate evaluation of patient experience, and reviews a report of responses.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The organization may gather feedback through a survey or may use another qualitative method (e.g., focus group, interviews).

Patient feedback must represent the patient population (including relevant subpopulations), and may not be limited to patients of one clinician.

***Factor 1:* Access to clinical care**

Access may include routine, urgent, after-hours and alternative appointment types such as telehealth.

Factor 2: **Communication**

Communication may include "feeling respected and listened to" and "being able to get answers to questions."

Factor 3: **Continuity of care**

Continuity of care may include a long-term, trusting relationship with specific members of the healthcare team, a consistent clinician and a system of accessibility to the clinician.

Factor 4: **Care coordination**

Care coordination may include being informed on referrals, changes in medications and lab or imaging results.

Factor 5: **Education and information**

Education and information may include materials on the patient's condition, symptoms, appropriate medication use, self-management tools and community resources.

Teaching tools include printed materials, videos, presentations, posts, models, group classes and peer educators.

Factor 6: **Patient engagement**

Patient engagement may include two-way communication between the patient and care teams, shared decision making and use of self-management tools.

Factor 7: **Respect for preferences**

Respect for preferences may include administrative, clinical, cultural, personal and other preferences.

Factor 8: **Whole-person care**

Whole-person care may include provision of comprehensive care and self-management support, emphasizing the continuum of care needs such as physical health, mental and behavioral health, routine and urgent care, health coaching, assistance and support for changing health habits and making health care decisions.

Exceptions

None.

Examples

Common validated patient experience tools in primary care

- Clinician and Group Consumer Assessment of Healthcare Providers and Systems.
- Primary Care Assessment Survey.
- Primary Care Assessment Tool.

Note: *Clinician Net Promoter Scores, a key indicator of overall patient satisfaction, does not replace a detailed and comprehensive assessment, and can be used in conjunction with another tool.*

Element B: Demonstrating Improvement on Patient Experience

The organization has a process to improve patient experience that includes:

1. **Reviewing patient experience data.**
2. **Establishing at least one measurable goal.**
3. **Taking action on at least one measurable goal.**
4. **Measuring improvement.**

Scoring

Met	Partially Met	Not Met
The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Reports, Materials

Scope of review

For All Surveys: NCQA reviews:

- *For factors 1,* 2: Evidence that the organization reviews patient experience data and goal setting.
- *For factor 3*: Materials, as evidence that the organization acts on a measurable goal.
- *For factor 4*: A report demonstrating measured improvement.

Look-back period

For All Surveys: Prior to the survey date.

Explanation

***Factor 1:* Reviewing patient experience data**

The organization reviews patient survey results from Element A to identify areas below benchmark or organizational targets. The organization may segment results by population, as needed.

***Factor 2:* Establish at least one goal**

The organization establishes at least one measurable goal based on the results in factor 1.

***Factor 3:* Taking action on at least one goal**

The organization demonstrates at least one action taken to meet the measurable goal identified in factor 2.

***Factor 4:* Measure improvement**

The organization measures whether actions taken improved the goal.

Exceptions

None.

Examples None.

Behavioral Health

BH 1: Access and Integration

The organization helps ensure that patients have timely access to behavioral health services, and promotes integration of behavioral care into medical care.

Intent

Patient outcomes are improved by ensuring that behavioral health needs are addressed promptly and effectively.

Element A: Demonstrating Access to Behavioral Health Services

The organization defines the scope of behavioral health services it provides internally, and which services require a referral.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Materials

Scope of review *For All Surveys:* NCQA reviews materials for how the organization defines the scope of behavioral health services it provides internally.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The organization defines the scope of behavioral health services it provides internally so patients receive care that is appropriate and safe to treat in the primary care setting.

The organization has materials (e.g., lists of in-house services that can be embedded, via telehealth, or contracted; documentation of staffing models; screenshots of EHR access; other integration examples) that include the conditions, levels of acuity and types of behavioral health concerns the organization's clinicians and care teams are equipped to treat.

The organization defines circumstances in which external behavioral health expertise is needed and a referral is required.

Exceptions

None.

Examples Based on office setting, staffing models and resource capabilities, XYZ Clinic documents that its internal behavioral health services include screening for depression, suicide risk, anxiety and alcohol use, brief interventions, short-term counseling, care management support and follow-up for mild to moderate behavioral health conditions that can be managed in the primary care setting.

The organization's internal clinicians manage patients whose symptoms are stable, low-risk and responsive to brief or structured interventions deliverable in the practice. For example, patients with mild depression or anxiety receive evidence-based brief therapy, medication management and monitoring through internally embedded behavioral health support.

Patients with complex diagnostic needs, severe or worsening symptoms, suspected psychosis and substance use disorders requiring specialty addiction care, or behavioral health needs requiring intensive outpatient, partial hospitalization or inpatient treatment, are referred to the appropriate local providers.

Element B: Behavioral Health Referrals

The organization has referral pathways to appropriate behavioral health services and providers for services it does not treat. The organization:

1. **Establishes relationships with behavioral health organizations.**
2. **Establishes expectations for exchange of information and coordination.**
3. **Monitors the referral for follow-up.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Materials

Scope of review *For All Surveys:* NCQA reviews:

- *For factor 1*: The process for establishing relationships with behavioral health providers.
- *For factor 2*: Materials as evidence of formal or informal agreements.
- *For factor 3:* Materials demonstrating follow-up and monitoring of referrals.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation The organization refers patients with behavioral health conditions that cannot be managed in primary care (including mental health and substance use disorders), especially for patients with complex or severe conditions.

The organization adheres to all applicable federal and state regulations governing collection and sharing of data as needed for coordination of care, treatment and payment.

***Factors 1, 2:* Relationships with behavioral health providers**

The organization has established relationships with both mental health and substance use disorder providers through formal or informal agreements that

establish expectations for exchange of information. The organization may use contracted telehealth providers, where clinically appropriate, or present existing internal processes if there is partial integration of behavioral services in the organization.

Factor 3: **Referral monitoring**

The organization tracks behavioral health through reasonable follow-up efforts to close the loop. Although closing the loop does not require confirmation that the patient received the referred service, the organization tracks whether the patient was able to access the referral, and documents follow-up communication, outcomes or next steps, recognizing that the decision to proceed ultimately rests with the patient.

The organization helps ensure that proper documentation supports the outcome of the referral, even if a patient denies services. A tracking report includes the date when the referral was initiated and the timing indicated for receiving the report. If the specialist does not send a report, the organization contacts the specialist and documents its attempt to retrieve the report.

Exceptions

None.

Examples

Factors 1, 2: **Relationships with behavioral health providers**

Riverside Health has established relationships with a network of behavioral health partners to support patients, including:

- A counseling center (outpatient therapy and psychiatric medication management).
- Recovery services (substance use disorder treatment, including medication-assisted treatment and intensive outpatient programs).
- Telehealth behavioral services (virtual therapy and psychiatry for patients with transportation or scheduling barriers, where clinically appropriate).

Riverside Health's behavioral health program manager conducts annual review of local and regional behavioral health providers. Providers are selected based on licensure, service availability, insurance acceptance and capacity to coordinate care. Riverside maintains a vetted directory of approved referral partners that is accessible to all clinicians.

Riverside maintains formal memoranda of understanding with counseling and recovery services that outline:

- Expectations for timely communication of intake summaries, treatment updates and discharge plans.
- Requirements for secure exchange of behavioral health information, in compliance with federal and state privacy laws.
- Procedures for coordinating care when patients have complex medical and behavioral needs.
- Contact points for urgent clinical concerns.

Riverside Health also has an informal workflow agreement with telehealth, documented in internal procedures, specifying:

- Guidelines to assess which patients are clinically appropriate for referral.
- How referrals are submitted.
- How follow-up documentation is returned.
- Expected turnaround times for communication.
- Telehealth's policies and procedures for assessing and managing a crisis situation (active suicidality or homicidality).
- Telehealth's guidelines and policies for discharging patients and discontinuing services due to escalating needs.

– Policies, procedures and communication to the primary care team when higher level of care is needed or virtual care is no longer appropriate.

Agreements help ensure that all referral partners understand Riverside's expectations for coordination and sharing information.

Factor 3: Referral monitoring

Riverside Health uses its EHR to track all behavioral health referrals. The behavioral care coordinator runs a weekly referral report that includes:

- The date when the referral was initiated.
- The assigned provider or organization.
- The expected time frame for receiving the initial consultation note (typically 7–10 days).
- The status (scheduled, pending, completed, overdue).

When a referral is completed, the coordinator uploads the specialist's report and marks the referral as closed.

If no documentation is received within the expected time frame, the coordinator contacts the behavioral health provider by secure message or phone, and documents the outreach attempt.

Escalation occurs after two unsuccessful attempts, with notification to the patient's primary care practitioner.

Element C: Integrated Services

The organization demonstrates internal coordination of behavioral health services through:

1. **Staffing models.**
2. **Integrated care plans.**
3. **Integrated communication.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Materials

Scope of review *For All Surveys:* NCQA reviews a documented process (workflows), reports or materials as evidence of integrated behavioral health services.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1*: Staffing models**

The organization has an integrated care team that incorporates internal behavioral health providers or external clinical consultants and care managers to coordinate behavioral health needs. Internal providers and external consultants must have advanced training in social work, counseling (e.g., marriage and family therapists) or nursing, and must have experience in a behavioral health setting.

The care manager is not required to be a clinician, but must have training, as defined by the organization, to support behavioral health needs in the primary care setting and to coordinate services. Duties may be conducted through telehealth where clinically appropriate.

***Factor 2:* Integrated care plans**

The organization maintains a single, integrated care plan between primary care and behavioral health providers, developed in collaboration with the patient, family or caregivers. The care plan specifies areas related to the patient's care, which may include:

- Patient goals.
- Treatment goals.
- Care team members, including primary care provider of record.
- Current medications.
- Current problems.

Factor 3: **Integrated communication**

The organization shares behavioral health information directly or through information exchange, while adhering to federal and state regulations. The organization has a process for timely communication of information between primary organizations and other specialty organizations. This may include automated alerts when new information has been shared.

Exceptions

None.

Examples

Factor 1: **Staffing models**

ABC Clinic employs a licensed clinical social worker onsite 4 days a week, and provides patients with brief interventions. The social worker joins daily huddles, conducts warm handoffs for screening follow-ups and collaborates with the care manager to track follow-up needs. The care manager coordinates follow-up appointments for patient behavioral health support.

Factor 2: **Integrated care plans**

ABC Clinic enables all providers to access a unified EHR. The primary care practitioner and behavioral health clinicians jointly create a single care plan that is documented in the EHR, and the plan is updated, as needed, to show collaborative changes.

A patient presents with uncontrolled diabetes and moderate depression. The integrated care plan includes:

- Patient goals:
  - Improve mood and energy.
  - Walk 20 minutes, 3 times per week.
- Treatment goals:
  - Begin SSRI medication.
  - Attend biweekly counseling sessions.
  - Complete diabetes education program.
  - Reduce A1c to target range.
- Care team members:
  - Primary care provider of record.
  - Licensed clinical social worker therapist.
  - Behavioral health care manager.
- Current medications.
- Current health status.

Factor 3: **Integrated communication**

ABC Clinic uses its EHR and a secure health information exchange for timely communication between primary care, behavioral health and external specialists. Communication processes include:

- Automated alerts sent to the primary care practitioner and the care manager when the social worker documents a new behavioral health note.
- Shared visit summaries are accessible to all care team members.
- Secure messaging between the primary care provider and the psychiatrist for medication questions.
- Release-of-information protocols that comply with federal and state behavioral health privacy regulations.

BH 2: Behavioral Health Screenings

The organization conducts routine behavioral health screenings and assessments using validated tools integrated into standard care workflows.

Intent

Early identification of behavioral health conditions through validated tools enables timely interventions and improves patient outcomes.

Element A: Routine Behavioral Health Screenings

The organization performs the following screenings using a validated tool:

1. **Depression.**
2. **Anxiety**
3. **Suicide risk.**
4. **Substance use disorder.**
5. **Alcohol use disorder.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Documented process, Reports

Scope of review *For All Surveys*: NCQA reviews the organization's documented process for how it conducts screenings and reports as evidence of screening results.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation A standardized tool collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The organization's process outlines:

- The standardized, validated and age-appropriate screening tools used to collect factors 1–5 at least annually.
- When screening is performed and integrated into routine care workflows.

Factors 1, 2: **Depression and suicide risk screenings**

The organization must have a formal process for routinely screening patients for depression. At a minimum, the organization performs a PHQ-2 for all patients.

The United States Preventive Services Task Force recommends screening for depression in all adults 18 and older in primary care settings. Validated tools include, but are not limited to, the PHQ-9, following a positive PHQ-2.

Pediatric screening for behavioral health provides opportunities for early interventions. The American Academy of Child and Adolescent Psychiatry recommends routine screening for depression in ages 8 and older. Tools for screening include, but are not limited to, the Behavioral Assessment System for Children and the PHQ-A, following a positive PHQ-2.

The organization has a process for routinely screening for suicide risk after a positive depression screen or when clinically indicated. Validated tools include, but are not limited to, the Columbia-Suicide Severity Rating Scale for ages 6+ or the Ask–Suicide-Screening Questions for ages 10–24.

Factor 3: **Anxiety screening**

The organization has a process for routinely screening patients for emotional distress and symptoms of anxiety. Validated tools include, but are not limited to, the GAD-2 or the GAD-7, which are appropriate for both adults and adolescents.

Factor 3: **Substance use disorder**

The organization screens for patient-reported substance use (which may include alcohol use) by using age-appropriate screening tools. Validated screening tools for adults may include, but are not limited to:

- ASSIST.
- DAST-10.
- TAPS.
- NIDA Quick Screen.

Validated screening tools for adolescents may include, but are not limited to:

- CRAFFT 2.1+N.
- S2BI.
- BSTAD.

Factor 4: **Alcohol use disorder**

The organization has a process for routinely screening patients for alcohol use disorder. The USPSTF recommends screening adults 18 years or older for alcohol misuse. The organization may use standardized tools including, but not limited, to the AUDIT (Alcohol Use Disorders Identification Test) or the CAGE Questionnaire.

AAP Bright Futures recommends clinicians screen all adolescents for alcohol use during all appropriate acute care visits, using developmentally appropriate screening tools such as the CRAFFT or Alcohol Screening and Brief Intervention for Youth.

Exceptions

None.

Examples None.

Element B: Clinically Indicated Behavioral Health Screenings

The organization performs at least one of the following screenings using a validated tool, based on the populations it serves or when clinically indicated:

1. **Pediatric behavioral health screening.**
2. **Post-traumatic stress disorder.**
3. **Attention-deficit/hyperactivity disorder.**
4. **Postpartum depression.**

Scoring

Met	Partially Met	Not Met
The organization meets 1-4 factors	No scoring option	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *For All Surveys*: NCQA reviews the organization's documented process for screening and reports as evidence of screening results.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation A standardized tool collects information using a current, evidence-based approach that was developed, field-tested and endorsed by a national or regional organization. The organization's process outlines the validated, standardized tool used to conduct at least two screenings in factors 1–5, and when screening is performed and integrated into routine care workflows. The organization determines whether screenings are administered routinely or when clinically indicated.

***Factor 1:* Pediatric behavioral health screening**

The organization may assess a variety of pediatric behavioral health conditions applicable to the patient population, including, but not limited to:

- Developmental delays.
- Oppositional defiant disorder.
- Autism spectrum disorder.
- Eating disorders.

***Factor 2:* Post-traumatic stress disorder**

The organization uses standardized tools to determine if patients have developed post-traumatic stress disorder (PTSD) using tools such as the PC-PTSD-5 for adults and older adolescents, or the UCLA PTSD Reaction index for children and adolescents.

Factor 3: **Attention deficit/hyperactivity disorder**

The organization assesses patients for attention deficit/hyperactivity disorder using tools such as the Vanderbilt Assessment Scale or the DSM-5 ADHD checklist for adults or children/adolescents.

Factor 4: **Postpartum depression**

The USPSTF recommends screening postpartum women for depression at 4–6 weeks postpartum. Bright Futures acknowledges that primary care practices see both infants and their families to potentially integrate postpartum depression screening into the well-childcare schedule at the 1-, 2-, 4 or 6-month well-child visits. Validated screening tools include, but are not limited to, the Edinburgh Postnatal Depression Scale.

Exception

Factor 1 is NA for organizations that do not treat pediatric populations.

Examples None.

BH 3: Evidence-Based Care

The organization provides interventions consistent with evidence-based guidelines when clinically appropriate for patients with behavioral health conditions.

Intent

Providing appropriate treatment ensures that patients receive safe, effective and timely care that is aligned with best practices to support symptom management.

Element A: Providing Interventions

Based on screening results from BH 2, Elements A and B, the organization:

1. **Delivers targeted interventions.**
2. **Prescribes appropriate medication or pharmacological interventions.**
3. **Defines and implements a crisis response and safety plan.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *For All Surveys:* NCQA reviews:

- *For factor 1:* The organization's process for how it provides interventions and reports or materials as evidence of interventions provided.
- *For factor 2:* Reports as evidence of prescribing medication or pharmacological interventions. The organization calculates the rate as the number of active empaneled patients receiving medication or pharmacologic treatment divided by the total number of active empaneled patients.
- *For factor 3:* The organization's crisis response and safety planning protocol (documented process) and materials as evidence that the protocol was implemented.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Interventions**

The organization's process outlines how it provides brief, targeted interventions within the scope of primary care for patients who screen positive for assessments in BH 2, Elements A and B.

Interventions are differentiated based on the type and severity of the condition identified. The process specifies:

- Conditions that trigger a specific type of intervention.
- Who is responsible for delivering the intervention.

- How interventions are delivered, including in-person, telehealth or hybrid approaches.

Brief interventions may include:

- Counseling.
- Medication.
- NARCAN.
- Test strips.
- Educational information.
- Other harm reduction tools.

Factor 2: **Prescribes appropriate interventions**

The organization may prescribe medication or other pharmacological interventions (e.g., medication assisted treatment) when deemed appropriate as part of the patient's behavioral health treatment. The organization must adhere to evidence-based prescribing guidelines and provide medication only for conditions within the organization's scope of treatment.

Factor 3: **Defining and implementing a crisis response and safety plan**

When immediate or high-risk concerns are identified, the organization defines a crisis response and safety plan that includes:

- Immediate safety planning procedures.
- Standard call-scripts for both regular business hours and after-hours pathways.
- Instructions for staff for handling life-threatening emergencies.
- Identifying and providing appropriate community crisis resources to the patient.

Exceptions

None.

Examples

Factor 1: **Targeted interventions**

During a routine visit, a patient completes the PHQ-9 and GAD-7 as part of BH 2, Elements A and B.

- PHQ-9 score: 18 (moderately severe depression).
- GAD-7 score: 14 (moderate anxiety).

The patient reports recent sleep disturbance, worsening irritability and intermittent passive thoughts of "not wanting to be here," but denies intent or a plan. Based on these results, Lakeside Family Health activates its post-screening workflow. The clinician follows the organization's documented intervention pathway process:

- The primary care clinician and behavioral health care manager meet with the patient during the same visit.

- The care manager provides a brief cognitive-behavioral intervention focusing on behavioral activation and coping strategies.
- The clinician schedules a follow-up telehealth check-in within 72 hours, per Lakeside's protocol for moderate-severity depression.
- The patient receives educational materials and a self-monitoring tool through the patient portal.

The organization's process specifies interventions that correspond to specific screening thresholds, ensuring consistent application across clinicians.

Factor 2: **Appropriate interventions**

Consistent with the organization's evidence-based prescribing guidelines, the clinician determines medication may benefit the patient.

The clinician prescribes an SSRI antidepressant following Lakeside's evidence-based medication management protocol. Before prescribing, the clinician reviews contraindications, explains side effects and outlines the expected time for symptom improvement. A follow-up medication check is scheduled for 2 weeks, per clinic protocol for new antidepressant starts.

The patient's primary care clinician and care manager coordinate to monitor side effects, adherence and early symptom response. If symptoms worsen or the patient does not respond over time, the workflow outlines when to initiate psychiatric consultation through Lakeside's tele-psychiatry partner.

Factor 3: **Crisis response and safety planning**

Although the patient denies intent, the clinician determines there is elevated risk, and activates the clinic's crisis response protocol.

The behavioral health care manager conducts a collaborative safety plan, including identifying personal warning signs, coping strategies, safe contacts and emergency steps. The clinician reviews life-threatening emergency instructions so the patient knows when to call 911 and how to contact the local mobile crisis team.

The care manager provides the harm reduction protocols, including a crisis hotline number, mobile crisis unit contact information and instructions for after-hours emergencies. Documentation is entered immediately into the EHR, following the organization's required template. Because Lakeside maintains a roster of community crisis partners, the care manager offers the patient optional same-day outreach to a crisis stabilization center.

Element B: Monitoring Patients Over Time

The organization monitors and assesses behavioral symptoms over time for patients by:

1. **Conducting periodic symptom measurement.**
2. **Tracking treatment response.**
3. **Adjusting treatment plans for patients who do not demonstrate improvement.**
4. **Defining clear referral triggers or escalation pathways.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source Reports, Documented process

Scope of review *For All Surveys:* NCQA reviews:

- *Factors 1–2:* Reports demonstrating that the organization periodically monitors and assesses patient behavioral health condition symptoms and treatment response over time.
- *Factors 3–4:* A plan (documented process) demonstrating adjustment in the treatment plan for patients who do not demonstrate improvement, and defining referral triggers or escalation pathways.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factors 1 and 2:* Periodic symptom measurement and tracking treatment response**

The organization conducts periodic and standardized symptom measurements at clinically appropriate intervals, using the validated screening tools used in BH 2, Elements A and B. Results are documented in the medical record and trended over time. The organization uses results to track treatment response to determine if the patient is improving, unchanged or worsening.

***Factor 3:* Adjusting treatment plans**

Treatment response status is documented to guide adjustments as needed. For patients who do not demonstrate improvement, the organization adjusts the documented treatment plan. Adjustments may include:

- Changing pharmacotherapy or psychotherapy dose/frequency.
- Addressing barriers to treatment.
- Adding or coordinating additional services (e.g., care management or peer support).

Factor 4: **Defining referral triggers or escalation pathways**

The organization defines referral triggers and timely escalation pathways if symptoms worsen or fail to improve or if risk increases. The organization must identify when patients' conditions exceed the scope of care defined in BH 1, Element A, and must initiate a referral if guideline-concordant care cannot be delivered within the scope.

Exceptions

None.

Examples None.

Clinical Quality

CQ 1: Quality Performance Measurement

The organization reports clinical quality measures, demonstrates performance and improves identified gaps.

Intent

The organization monitors and improves clinical quality outcomes through standardized measurement to identify gaps, enhance patient care and promote quality improvement.

Element A: Clinical Measurement Reporting

The organization reports the following measures, based on its patient population, to demonstrate clinical performance:

1. **Breast Cancer Screening (CMS125v13).**
2. **Cervical Cancer Screening (CMS124v13).**
3. **Colorectal Cancer Screening (CMS130v13).**
4. **Screening for Falls (CMS139v13).**
5. **Use of High-Risk Medications in Older Adults (CMS156v13).**
6. **Appropriate Treatment for Upper Respiratory Infection (CMS154v13).**
7. **Glycemic Status Assessment Greater than 9% (CMS122v13).**
8. **Controlling High Blood Pressure (CMS165v13).**
9. **Screening for Depression and Follow-up Plan (CMS2v14).**
10. **Childhood Immunizations (CMS117v13).**
11. **Follow-up Care for Children Prescribed ADHD Medication (CMS136v14).**

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	The organization partially meets the requirement	The organization does not meet the requirement

Data source Reports

Scope of review *For All Surveys:* NCQA reviews the organization's most recent reports demonstrating a complete calendar year (January–December) of data. For each factor, the organization reports:

- The eligible population.
- The rate.

Look-back period *For All Surveys:* The most recent complete calendar year.

Explanation The organization uses the eCQM specifications based on the measurement year reported. The organization reports the measures applicable to their patient populations at the aggregated organization level.

- If the organization serves the adult population (ages 18–64), the organization reports on factors 1–3 and factors 6–9.
- If the organization serves the older adult population (ages 65 and older), the organization reports on factor 1 and factors 3–9.
- If the organization serves a pediatric population (ages 0–17), the organization reports on factors 9–11.

If the organization serves more than one population type, it reports all applicable measures.

All measures are required for organizations that serve adults, older adults and pediatrics.

Exceptions

None.

Examples None.

Element B: Demonstrating Clinical Measurement Performance—50th Percentile

The organization demonstrates performance at or above the 50th percentile in peer comparison on at least three measures reported in Element A.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review *For All Surveys*: NCQA reviews the organization's most recent reports demonstrating a complete calendar year (January–December) of data.

Look-back period *For All Surveys:* The most recent complete calendar year.

Explanation The organization demonstrates performance at or above the 50th percentile in peer comparison on the measures reported in CQ 1, Element A.

Exceptions

None.

Examples None.

Element C: Demonstrating Clinical Measurement Performance—80th Percentile

The organization demonstrates performance at or above the 80th percentile in peer comparison on at least three measures reported in Element A.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review *For All Surveys:* NCQA reviews the organization's most recent reports demonstrating a complete calendar year (January–December) of data.

Look-back period *For All Surveys:* The most recent complete calendar year.

Explanation The organization demonstrates performance at or above the 80th percentile in peer comparison on the measures they report in CQ 1, Element A.

Exceptions

None.

Examples None.

Element D: Improving Disparity Gaps

The organization addresses a gap in at least one clinical quality measure across the patient population by:

1. **Identifying the gap.**
2. **Creating a plan or strategy for improvement.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process

Scope of review *For All Surveys:* NCQA reviews reports identifying at least one gap and a plan (documented process) for gap closure.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation ***Factor 1:*** **Identifying gaps**

The organization identifies populations, conditions or services where measurement gaps exist, and may choose a disparity type to assess (e.g., service performed, race/ethnicity, language, geography, clinical area).

The organization identifies gaps in non-respondence to improve the rate, and gaps in performance results (e.g., low rates in breast-cancer screening for certain populations).

***Factor 2:* Plan for gap closure**

The organization develops and implements an action plan to address at least one identified measure gap in factor 1. The plan includes:

- Specific interventions.
- A timeline for completion.
- Roles of staff responsible.
- How progress will be monitored.

Exceptions

None.

Examples

***Factor 1:* Identifying gaps**

The organization reviewed its Screening for Falls (CMS139v13) results across the past measurement year and identified gaps:

- The rate of fall-risk screening was significantly lower among:
  - Patients aged 80+.
  - Patients whose preferred language is Spanish.
  - Patients living in rural ZIP codes.
- Gaps in non-respondence:
  - Chart review and outreach logs showed that 38% of non-completed fall-risk screenings resulted from patients not responding to outreach attempts.
- Gaps in performance results:
  - Performance rates were lowest among individuals with:
  - Multiple chronic conditions (diabetes and cognitive decline).
  - Recent ED utilization.

***Factor 2:* Plan for gap closure**

- Interventions to improve outreach for non-response populations:
  - Implement multilingual outreach (Spanish/English automated reminders and personalized calls).
  - Add weekend and after-hours outreach blocks for caregivers of older adults.
  - Embed fall-risk screening prompts into the EHR for every annual wellness visit.
  - Activate clinical decision support so uncompleted screenings trigger a task for the RN care coordinator.

- Interventions to address performance gaps:
  - Partner with community health workers to conduct home-based screenings for patients aged 80+ or with mobility limitations.
  - Provide fall-prevention educational materials in English and Spanish.
- Timeline for completion:
  - Q1: Launch enhanced multilingual outreach and EHR prompt.
  - Q2: Expand home-based screenings and begin monthly gap-closure reports.
  - Q3: Evaluate progress and adjust workflows; additional staff training if needed.
  - Q4: Reassess performance and disparities; finalize year-end reporting.
- Roles and responsibilities:
  - RN Care Coordinator: Reviews fall-risk prompts, conducts follow-up calls, schedules screening visits.
  - Population Health Analyst: Monitors non-response rates and generates monthly reports.
  - Community Health Worker: Conducts targeted screenings in patients' homes.
  - Quality Manager: Oversees execution of the plan, ensures alignment with organizational measurement strategy.
- Monitoring progress:
  - Monthly dashboard tracking:
    - Screening completion rates by race/ethnicity, language, and ZIP code.
    - Non-response trends and reasons.
    - Comparative analysis of intervention groups vs. baseline.
    - Quarterly leadership review to update or revise interventions as required.

Data Management and Exchange

DME 1: Data Integration and Exchange

The organization integrates core or advanced sources of data to support an understanding of patient care and inform care delivery and coordination activities.

Intent

The organization integrates data from sources appropriate to its patients and services.

Element A: Core Data Integration

The organization integrates data from at least two core sources appropriate to its patients and services, and annually evaluates whether additional sources are needed. Core sources include:

1. **Encounter or claims data.**
2. **Laboratory data.**
3. **Electronic health record data.**
4. **Health service programs in the organization.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-4 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews evidence of data source use or a system report with data sources.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation **Data integration** is combining data from multiple sources or databases. The organization may limit data integration to the minimum necessary to identify and support patient needs. Core data sources include the following.

Factor 1: **Encounter or claims data**

The organization integrates both medical and behavioral health encounters or claims data.

Factor 2: **Laboratory data**

No additional explanation needed.

Factor 3: **Electronic health record data**

Integrating EHR data from one organization meets the intent of this requirement.

Factor 4: **Health service programs within the organization.**

Programs may include care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identifying eligible patients and determining care needs.

Examples

Factor 3: **EHR integration**

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from organizations or clinicians.

Factor 4: **Health services programs in the organization**

- Disease management.
- Wellness coaching.
- Care management.

Element B: Advanced Data Integration

At least annually, the organization ingests and integrates data from at least two advanced sources into its systems and workflows, and evaluates if additional data sources should be integrated. Advanced sources include:

1. **Health information exchanges.**
2. **All-payer claims databases.**
3. **Community of regional data collaborative.**
4. **External hospital or health system feeds.**
5. **External specialty data sources (including behavioral health data sources).**
6. **Immunization registries or immunization information systems.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-6 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews evidence of data source use or a system report with data sources.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation **Data integration** is combining data from multiple sources or databases. Advanced data sources typically aggregate information across multiple entities, care settings and data systems. The organization may limit data integration to the minimum necessary to identify and support patient needs.

Factor 1: **Health information exchanges**

The organization accesses data from regional, community or health system health information exchange systems that share patient data electronically across organizations. This includes comparable multi-organization data networks that aggregate clinical data across providers.

Factor 2: **All-payer claims database**

The organization accesses data from all-payer claims databases or other comprehensive claims repositories from multiple insurers that allow analysis of total cost of care and care received outside the organization's system.

Factor 3: **Community of regional data collaborative**

The organization accesses data from community-based or regional data collaboratives that bring together information from multiple health care entities.

Factor 4: **External hospital or health system feeds**

The organization receives and uses data feeds from external hospitals or health systems such as admission, discharge and transfer notifications or hospitalization summaries.

Factor 5: **External specialty data sources**

The organization accesses and integrates data from external specialty providers or specialty data sources such as consultation reports and referral outcomes.

Factor 6: **Immunization registries or immunization information systems**

The organization accesses data from immunization registries or information systems to obtain vaccination histories completed outside the organization.

Examples

Factor 3: **Community of regional data collaboratives**

- Shared population-level dashboards combining data from multiple community providers.

Element C: Bidirectional External Exchange of Information

The organization demonstrates the electronic exchange of information with external entities such as:

1. **Regional health information organizations or other health information exchange sources.**
2. **Another clinician or care facility, for care transitions.**
3. **Clinical data exchange with payers.**
4. **Public health, specialty or disease registries.**
5. **Pharmacy data exchange.**

Scoring

Met	Partially Met	Not Met
The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews evidence of factors 1–5 being performed.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation NCQA assesses the organization's capability to electronically exchange clinical information with external entities to support coordinated care, transitions and continuous quality improvement. The focus is on real-time, two-way interoperability workflows such as sending clinical summaries or care notifications to partners, and receiving outside information in workflows, demonstrating that the organization is active in the broader data ecosystem.

Organizations can demonstrate this exchange in multiple ways: ADT messages, C-CDAs, QRDA, VXU and flat files may be used to demonstrate factors 1–5.

Factor 1: **Regional health information organizations or other HIEs**

The organization exchanges patient health information electronically through a regional health information organization or health information exchange. This may include encounters, clinical summaries or notification of patient activity outside the organization.

Factor 2: **Another provider or care facility**

The organization electronically exchanges clinical information with an external provider or care facility to support care transitions. This may occur during referrals, hospital admissions or discharges or transfers between care settings.

Factor 3: **Clinical data exchange with payers**

The organization electronically exchanges clinical data with payers to support care delivery, quality or payment-related activities. This may include clinical documentation, care plans, or other health information to support payer requirements.

Factor 4: **Public health, specialty or disease registries**

The organization engages with public health and clinical registries bidirectionally by electronically submitting required data and, where possible, retrieving patient-specific information or aggregate feedback.

Factor 5: **Pharmacy data exchange**

The organization engages in bidirectional exchange with pharmacies or pharmacy networks.

Examples

***Factor 4*: Registries**

- Send data on cancer cases to a regional cancer registry and receive notifications or outcomes updates from the registry to inform ongoing patient care (not all registries support data queries back).
- Submit immunization records to the state Immunization Information System for each vaccine administered at the organization.

***Factor 5:* Pharmacy exchange**

- Send electronic prescriptions to patients' pharmacies and receive medication fill status or history data electronically (via pharmacy network exchanges or direct interfaces).

DME 2: Use of Fast Healthcare Interoperability Resources (FHIR®)

The organization uses FHIR data and reports digital quality measures.

Intent

Advance the organization's use of FHIR by progressing from foundation data access to scalable, standards-based use of FHIR data for quality measurement and care improvement.

Element A: FHIR Data Integration Capability

The organization establishes foundational FHIR data integration capabilities to support the retrieval or conversion of key patient data into standardized FHIR resources. The organization demonstrates:

1. **Technical infrastructure for FHIR.**
2. **Data conversion to FHIR.**
3. **Mapping and terminology readiness.**

Scoring

Met	Partially Met	Not Met
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports, Materials

Scope of review *For All Surveys:* NCQA reviews reports or materials (e.g., screenshots) for evidence of system configuration for factors 1–3, which may include interface or technical documentation, demonstration outputs confirming the presence of FHIR R4 support, system report/output of a Patient FHIR resource demonstrating FHIR capability (using synthetic or de-identified data). .

Look-back period *For All Surveys:* Prior to the survey date.

Explanation **FHIR** is designed to allow medical data to flow seamlessly between different systems by using APIs and common data formats (JSON) to make health data access faster and more flexible.

Factor 1: **Technical infrastructure for FHIR**

The organization establishes a health IT environment (e.g., certified EHR or data platform) that supports HL7® FHIR Release 4 (R4) APIs and data models. Core system components (or vendor solutions) enable secure access to patient data via FHIR, or allow conversion of internal data to FHIR format according to recognized standards (e.g., US Core profiles aligned with USCDI data classes).

Factor 2: **Data conversion to FHIR**

The organization demonstrates it can generate a Patient FHIR resource from its systems. For example, it might extract a test patient's demographic and clinical information and output a Patient resource in JSON. This can be shown via a sample FHIR resource or a query result from the EHR's FHIR API. Content should be de-identified or synthetic to avoid exposing PHI.

The goal is to show that the organization can represent clinical data in a vendor-agnostic, machine-readable format.

Factor 3: **Mapping and terminology readiness**

The organization ensures that its data (especially data needed for quality measures like diagnoses, lab results, medications, immunizations) are mapped to standard codes and fields (e.g., using LOINC for labs, SNOMED CT/ICD-10 for conditions) in its systems. Mapping readiness is critical: Data coded to national standards can be more reliably transformed into FHIR without losing meaning.

Evidence may include documenting how data systems map internal fields to standard codes, or how the organization handles nonstandard data through mapping tables. This step helps ensure that the organization is prepared for more advanced FHIR data integration, where semantic consistency is required.

Examples

Factor 1: **Technical infrastructure for FHIR**

- ONC-certified vendor confirmation or admin console screenshots indicating FHIR R4 API endpoints are active and accessible.

Factor 2: **Data conversion to FHIR**

- A synthetic patient record exported via FHIR, showing a Patient resource in JSON format.

Factor 3: **Mapping and terminology readiness**

- A data dictionary excerpt or code mapping file indicating that laboratory results are mapped/stored with LOINC codes, or a workflow description for how staff enter standardized codes for key data elements.

Element B: FHIR Data Production and Validation

The organization expands its FHIR capabilities to produce complete, interoperable data sets at scale and ensure their conformance to standard profiles. The organization demonstrates:

1. **Production of comprehensive FHIR datasets.**
2. **Integration of diverse data sources.**
3. **Conformance to the Implementation Guide.**

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source System reports/exports (using test or de-identified data) showing FHIR bundle (JSON); logs from NCQA's FHIR validation tool run (with no PHI)

Scope of review *For All Surveys:* NCQA reviews submission of a multi-resource FHIR data sample (e.g., a synthetic patient's bundle) and accompanying validation results.

For factor 1: NCQA reviews the FHIR bundle.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation All factors will be demonstrated through the same JSON file. File data must represent a test or synthetic patient with no real patient health information.

***Factor 1:* Production of comprehensive FHIR datasets**

The organization demonstrates the ability to generate a FHIR bundle containing multiple interrelated resources representing a clinical episode or patient summary. This demonstrates that various data domains (e.g., demographics, encounters, labs, diagnoses, treatments) can be exported or accessed in FHIR format across the organization's systems.

The submitted JSON file must contain a FHIR bundle with the following:

- A Patient resource for demographics
- An Encounter resource representing two visits.
- Observation resources.
- Condition resources.
- Procedure resources for clinical intervention
- A Medication Dispense resource for diabetes medications
- A claim and/or explanation of benefits for administrative data.
- An Immunization resource.

Factor 2: **Integration of diverse data sources**

The organization demonstrates that it uses external data sources (e.g., from a health information exchange, immunization registry, payer or specialty provider) to supplement its internal records, and maps or converts them into FHIR format.

Factor 3: **Conformance to Implementation Guide**

Routine use of validation tools or services to check that FHIR resources conform to HEDIS Core IG. For example, the organization validates its FHIR bundle against the NCQA-offered HEDIS FHIR Core IG or HL7 US Core profiles to ensure that required elements, code bindings and formats are correct. Any errors identified (e.g., missing required fields, incorrect code systems) are addressed as part of a data quality improvement process.

The organization demonstrates that data meet standard definitions and criteria by validating resources against the HEDIS FHIR Core IG. For example, if the HEDIS IG expects a certain profile for an observation (with LOINC coded test results and units), the organization's output is checked for those specifics. The approved IG is the HEDIS Core with any APC-specific additions (Appendix xx). NCQA conducts IG-based validation against the submitted bundle to determine if the required fields are present and if all profiles and required fields have been met.

Examples

Factor 1: **Production of FHIR data sets**

A FHIR bundle for diabetes may contain:

- Patient information.
- Multiple encounter entries.
- Condition entries for "Diabetes" and related conditions.
- Observation entries for HbA1c lab results.
- Medication requests for diabetes medications.
- Immunization records.

Factor 2: **Integration of diverse data sources**

- Interface documentation or architecture diagram illustrating how the organization consumes external data (e.g., a health information exchange FHIR API feed or nightly batch conversion of external CCD files to FHIR) and merges it into internal data stores.

Factor 3: **Conformance to implementation guide**

- Validation report or logs (with synthetic data) showing results of running the bundle against NCQA's HEDIS Core FHIR IG (e.g., errors or "Valid" status per resource).

Element C: FHIR Digital Quality Measure Reporting

The organization executes and reports on digital quality measures (dQM) using FHIR standards:

1. **Computes dQMs using FHIR data.**
2. **Generates a FHIR MeasureReport.**
3. **Demonstrates scalability and routine use.**

Scoring

Met	Partially Met	Not Met
The organizations meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Reports (JSON files)

Scope of review *For All Surveys:* NCQA reviews a JSON file with aggregated rates for each measure submitted.

Look-back period *For All Surveys:* Prior to the survey date.

Explanation

***Factor 1:* Measure execution**

The organization computes and executes dQMs using FHIR data and measure definitions. Quality measurement can occur automatically by applying measure logic to FHIR data. The organization might use a vendor's FHIR-based quality reporting module or an open-source or internal FHIR CQL execution engine. The user does not have to manually calculate numerators or denominators, but relies on computable measure definitions.

The dQMs included in the APC program are:

- Colorectal cancer screening (COL-CD).
- Appropriate Treatment for Upper Respiratory Infection (URI-CD).
- Blood Pressure Control (BPC-CD).

***Factor 2:* Generating FHIR measure report**

After calculation, the organization can output results in a standard format as a FHIR MeasureReport resource, following the HL7 DEQM (Data Exchange for Quality Measures) IG, which includes structured reporting of measure outcomes. The measure report should contain the key aggregated results (e.g., population counts, measure score) that could be electronically submitted to an accreditor or payer.

***Factor 3:* Demonstrating scalability and routine use**

The organization demonstrates repeatable measure computation on different data sets or at intervals (e.g., quarterly runs on live data using a similar pipeline). The organization may also show how dQM results feed into quality improvement cycles or external reporting commitments. The goal is to ensure the capability is operationalized and repeatable.

Examples

***Factor 1:* Measure execution**

- A log file from a measure execution engine (with synthetic data) showing intake of FHIR patient data and generation of measure calculations (e.g., listing patients in numerator/denominator for a measure).

***Factor 2:* Generating FHIR measure report**

- A FHIR MeasureReport JSON output illustrating measure results structure (e.g., measure ID, period, population counts, numerator count).

***Factor 3:* Demonstrating scalability and routine use**

- Process documentation or standard operating procedure describing dQM use (e.g., monthly automated run using FHIR data to produce measure results for internal quality monitoring).