

Advancing Health Equity

Through national
health care quality
standards



Connecticut Health
FOUNDATION





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As U.S. health care systems pay more attention to quality improvement, health care providers are using national health care quality standards to measure progress. This publication lists several of these national standards and highlights how the advancement of health equity — achieving the same levels of quality and health status for all populations — can be integrated into efforts to improve health care quality. Although these standards have been developed by a variety of governmental and private organizations, they are inter-related and often build on each other. By listing and highlighting the elements in these standards that advance health equity, this publication can be used as a guide for health care providers, policy makers, and advocates to address equity issues while improving overall health care quality.

The first standards listed are from the implementation of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, which makes available billions of dollars to hospitals, physicians, and community health clinics that meet standards for the meaningful use of certified electronic health records (EHR). This “meaningful use” requirement means not just installing EHRs, but using EHR technology to improve health care quality by having patients’ health information more accurately recorded, more organized, and more accessible to both providers and patients. The standards listed here are the ones that physicians are required to meet. The Centers for Medicare & Medicaid Services (CMS) is administering this “meaningful use” program, in coordination with the Office of National Coordinator for Health Information Technology (ONCHIT).

The next standards listed are from the National Committee for Quality Assurance (NCQA) for primary care “patient-centered medical homes” (PCMHs), and for “accountable care organizations” (ACOs). These two models for changing health care delivery systems, both of which prioritize health care quality, are being implemented by physicians and other health care providers.

Finally, both the NCQA, with its standards for “distinction in multicultural health care,” and the National Quality Forum (NQF) — another leading national quality organization, with its “framework and preferred practices for measuring and reporting cultural competence” — have developed specific standards to ensure the integration of equity into health care quality improvement.

This publication provides a useful reference by listing these related national quality standards, and indicating how they integrate advancing equity as part of national efforts to improve the quality of health care for all Americans.

A NOTE ABOUT USING THIS CHART

This chart provides specific details about requirements for implementation of medical homes, and for meeting a variety of national health care quality standards. It can be used as a reference both by those involved in implementation of medical homes, as well as by those in positions to advocate for this model and for the improvements in health equity, care quality, and cost savings that it offers. For instance: A primary care practice that wants to achieve recognition as a patient-centered medical home can use the “Patient-Centered Medical Home” section of the chart to learn what steps are involved.

In addition:

- References are included so that users can go to the source materials for details and background information.
- Each type of requirement is color coded across categories of users.

-  = Establishment of medical home/ access to medical home
-  = Patient data
-  = Managing care
-  = Coordinating care
-  = Sharing information with patients
-  = Improving quality

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STAGE 1 REQUIREMENTS FOR CERTIFIED ELECTRONIC HEALTH RECORDS

Reference: Center for Medicare & Medicaid Services (CMS) Electronic Health Record Incentive Program Final Rule, 75 Fed. Reg. 44314-44588 (July 28, 2010) can be found at: <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>

National Committee for Quality Assurance, Crosswalk of Meaningful Use and Patient-Centered Medical Home (2011) can be found at: <http://www.ncqa.org/tabid/631/Default.aspx>



PATIENT DATA

REFERENCE	REQUIREMENTS
42 CFR 495.6(d)(7)	<ul style="list-style-type: none"> Record patient demographics, including race, ethnicity, preferred language for more than 50% of patients. ▲
42 CFR 495.6(d)(8)	<ul style="list-style-type: none"> Record and chart changes in vital signs for more than 50% of patients age 2 and over.
42 CFR 495.6(d)(9)	<ul style="list-style-type: none"> Record smoking status for 50% patients age 13 and over.

CFR = Code of Federal Regulations ▲ Requirement most directly relevant to issues of health equity.

MANAGING CARE

REFERENCE	REQUIREMENTS
Optional 42 CFR 495.6(e)(3)	<ul style="list-style-type: none"> Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.
Optional 42 CFR 495.6(e)(4)	<ul style="list-style-type: none"> Use EHR to send reminders to patients per patient preference for preventive/follow-up care to 20% patients 65 years or older or 5 years old and younger.
42 CFR 495.6(d)(3)	<ul style="list-style-type: none"> Maintain an up-to-date problem list of current and active diagnoses for 80% patients.
42 CFR 495.6(d)(11)	<ul style="list-style-type: none"> Implement one clinical decision support rule relevant to specialty or of high clinical priority.
42 CFR 495.6(d)(5)	<ul style="list-style-type: none"> Maintain active medication list for 80% patients.
42 CFR 495.6(d)(6)	<ul style="list-style-type: none"> Maintain active medication allergy list for 80% patients.
Optional 42 CFR 495.6(e)(7)	<ul style="list-style-type: none"> Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the eligible provider.
42 CFR 495.6(d)(1)	<ul style="list-style-type: none"> Use computerized physician order entry for medication orders for more than 30% of patients.
42 CFR 495.6(d)(4)	<ul style="list-style-type: none"> Generate and transmit permissible prescriptions electronically for more than 40% of patients.
42 CFR 495.6(d)(2)	<ul style="list-style-type: none"> Implement drug-drug and drug-allergy checks electronically.

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MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
Optional 42 CFR 495.6(e)(1)	<ul style="list-style-type: none"> Implement drug-formulary checks.
Optional 42 CFR 495.6(e)(6)	<ul style="list-style-type: none"> Use EHR to identify and provide patient-specific education resources for more than 10% of patients.

CFR = Code of Federal Regulations EHR = Electronic Health Record

COORDINATING CARE

REFERENCE	REQUIREMENTS
Optional 42 CFR 495.6(e)(2)	<ul style="list-style-type: none"> Incorporate clinical lab test results into EHR as structured data for more than 40% of lab tests ordered.
42 CFR 495.6(d)(14)	<ul style="list-style-type: none"> Capability to electronically exchange key clinical information among providers of care and patient-authorized entities.
Optional 42 CFR 495.6(e)(8)	<ul style="list-style-type: none"> Provide summary care record for each transition of care and referral for more than 50% of patients.

CFR = Code of Federal Regulations EHR = Electronic Health Record

SHARING INFORMATION WITH PATIENTS

REFERENCE	REQUIREMENTS
42 CFR 495.6(d)(13)	<ul style="list-style-type: none"> Provide clinical summaries for patients for each office visit within 3 business days for more than 50% of patients.
42 CFR 495.6(d)(12)	<ul style="list-style-type: none"> Provide patients with an electronic copy of their health information, upon request within 3 business days to 50% of patients who request.
Optional 42 CFR 495.6(e)(5)	<ul style="list-style-type: none"> Provide more than 10% of patients with timely electronic access to their health information within 4 business days of the information being available to the eligible provider.
42 CFR 495.6(d)(15)	<ul style="list-style-type: none"> Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities .

CFR = Code of Federal Regulations EHR = Electronic Health Record

IMPROVING QUALITY

REFERENCE	REQUIREMENTS
42 CFR 495.6(d)(10)	<ul style="list-style-type: none"> Report ambulatory clinical quality measures to CMS or state (Medicaid).
Optional 42 CFR 495.6(e)(9)	<ul style="list-style-type: none"> Capability to submit electronic data to immunization registries and actual submission according to applicable law and practice.
Optional 42 CFR 495.6(e)(10)	<ul style="list-style-type: none"> Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.

CFR = Code of Federal Regulations CMS = Centers for Medicare and Medicaid Services

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PROPOSED STAGE 2 REQUIREMENTS FOR CERTIFIED ELECTRONIC HEALTH RECORDS

Reference: Center for Medicare & Medicaid Services (CMS)

Electronic Health Record Incentive Program Stage 2 Proposed Rule, 77 Fed. Reg. 13698 -13829 (March 7, 2012) can be found at:

<http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf>



ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME

REFERENCE	REQUIREMENTS
42 CFR 495.6(j)(17)(ii)	<ul style="list-style-type: none"> Secure electronic messages are sent to more than 10% of patients.

CFR = Code of Federal Regulations

PATIENT DATA

REFERENCE	REQUIREMENTS
45 CFR 495.6(j)(3)(ii)	<ul style="list-style-type: none"> More than 80% of patients have demographics recorded as structured data. [▲]
45 CFR 495.6(j)(3)(i)(A)	<ul style="list-style-type: none"> Preferred language.
45 CFR 495.6(j)(3)(i)(C)	<ul style="list-style-type: none"> Race.
45 CFR 495.6(j)(3)(i)(D)	<ul style="list-style-type: none"> Ethnicity.
42 CFR 495.6(j)(4)(ii)	<ul style="list-style-type: none"> More than 80% of patients have blood pressure, height/length and weight recorded as structured data.
42 CFR 495.6(j)(5)(ii)	<ul style="list-style-type: none"> More than 80% of patients age 13 and over have smoking status recorded.

CFR = Code of Federal Regulations [▲] Requirement most directly relevant to issues of health equity.

MANAGING CARE

REFERENCE	REQUIREMENTS
Optional 42 CFR 495.6(k)(2)(ii)	<ul style="list-style-type: none"> More than 20% of patients have structured data entry for one or more first degree relatives.
42 CFR 495.6(j)(8)(ii)	<ul style="list-style-type: none"> Generate at least one report listing patients with a specific condition.
42 CFR 495.6(j)(9)(ii)	<ul style="list-style-type: none"> More than 10% of patients who had an office visit sent a reminder, per patient preference.

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MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
42 CFR 495.6(j)(6)(ii)	<ul style="list-style-type: none"> Implement five clinical decision support interventions related to five or more clinical quality measures.
42 CFR 495.6(j)(13)(ii)	<ul style="list-style-type: none"> Perform medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the eligible provider.
42 CFR 495.6(d)(1)(ii)(B)	<ul style="list-style-type: none"> More than 30% of medication orders are created using computerized physician order entry.
42 CFR 495.6(j)(2)(ii)	<ul style="list-style-type: none"> More than 65% of permissible prescriptions are compared to at least one formulary and transmitted electronically.
42 CFR 495.6(j)(6)(ii)(B)	<ul style="list-style-type: none"> Has enabled functionality for electronic drug-drug and drug-allergy interaction checks.
42 CFR 495.6(j)(12)(ii)	<ul style="list-style-type: none"> Provide patient-specific education resources to more than 10% of patients at office visits.

CFR = Code of Federal Regulations

COORDINATING CARE

REFERENCE	REQUIREMENTS
42 CFR 495.6(j)(1)(ii)	<ul style="list-style-type: none"> More than 60% of medication, lab, and radiology orders are recorded using computerized provider order entry.
42 CFR 495.6(j)(6)(ii)	<ul style="list-style-type: none"> More than 55% of clinical lab results are incorporated in EHR as structured data.
Optional 42 CFR 495.6(k)(1)(ii)	<ul style="list-style-type: none"> More than 40% of all scans and imaging tests accessible electronically.
42 CFR 495.6(j)(14)(ii)(A)	<ul style="list-style-type: none"> Provide summary of care record for more than 65% of transitions of care and referrals; summary of care record to include patient race, ethnicity, preferred language (77 Fed. Reg. 13722).[▲]
42 CFR 495.6(j)(14)(ii)(B)	<ul style="list-style-type: none"> Electronically transmit summary of care record for more than 10% of transitions of care and referrals to a recipient without an organizational affiliation and using a different EHR vendor; summary of care record to include patient race, ethnicity, preferred language (77 Fed. Reg. 13722).[▲]

CFR = Code of Federal Regulations EHR = Electronic Health Record ▲ Requirement most directly relevant to issues of health equity.

SHARING INFORMATION WITH PATIENTS

REFERENCE	REQUIREMENTS
42 CFR 495.6(j)(11)(ii)	<ul style="list-style-type: none"> Provide clinical summaries within 24 hours for more than 50% of patients; clinical summaries include patient race, ethnicity, preferred language (77 Fed. Reg. 13716).
42 CFR 405.6(j)(10)(ii)(A)	<ul style="list-style-type: none"> More than 50% patients provided online access to electronic health information (within 4 business days after information available to the eligible provider); electronic health information includes patient race, ethnicity, preferred language (77 Fed. Reg. 13720).
42 CFR 405.6(j)(10)(ii)(B)	<ul style="list-style-type: none"> More than 10% of patients view, download or transmit to a third party their health information electronically.
42 CFR 495.6(j)(16)(ii)	<ul style="list-style-type: none"> Conduct or review a security risk analysis and implement updates as necessary.

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CFR = Code of Federal Regulations

IMPROVING QUALITY

REFERENCE	REQUIREMENTS
42 CFR 495.8(a)(2)(ii)	<ul style="list-style-type: none"> • Report clinical quality measures to CMS or state (Medicaid).
42 CFR 495.6(j)(15)(ii)	<ul style="list-style-type: none"> • Successful ongoing submission of electronic immunization data to immunization registry or immunization information system.
Optional 42 CFR 495.6(k)(3)(ii)	<ul style="list-style-type: none"> • Successful ongoing submission of electronic syndromic data to public health agency.
Optional 42 CFR 495.6(k)(4)(ii)	<ul style="list-style-type: none"> • Successful ongoing submission of electronic cancer case information to a cancer registry.
Optional 42 CFR 495.6(k)(5)(ii)	<ul style="list-style-type: none"> • Successful ongoing submission of electronic specific case data to a specialized registry (other than a cancer registry).

CFR = Code of Federal Regulations CMS = Centers for Medicare and Medicaid Services

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National Committee for Quality Assurance (NCQA)

PATIENT-CENTERED MEDICAL HOME

Reference: Patient-Centered Medical Home (PCMH) Recognition Program (2011) can be found at: <http://www.ncqa.org/tabid/631/Default.aspx>

National Committee for Quality Assurance, Crosswalk of Meaningful Use and Patient-Centered Medical Home (2011) can be found at: <http://www.ncqa.org/tabid/631/Default.aspx>



ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME

REFERENCE	REQUIREMENTS
PCMH 1A	<ul style="list-style-type: none"> • Access during office hours.
PCMH 1A1	<ul style="list-style-type: none"> • Providing same-day appointments.
PCMH 1A2	<ul style="list-style-type: none"> • Providing timely clinical advice by telephone during office hours.
PCMH 1A3	<ul style="list-style-type: none"> • Providing timely clinical advice by secure electronic messages during office hours.
PCMH 1A4	<ul style="list-style-type: none"> • Documenting clinical advice in the medical record.
PCMH 1B	<ul style="list-style-type: none"> • After-hours access.
PCMH 1B1	<ul style="list-style-type: none"> • Providing access to routine and urgent-care appointments outside regular business hours.
PCMH 1B2	<ul style="list-style-type: none"> • Providing continuity of medical record information for care and advice when the office is not open.
PCMH 1B3	<ul style="list-style-type: none"> • Providing timely clinical advice by telephone when the office is not open.
PCMH 1B4	<ul style="list-style-type: none"> • Providing timely clinical advice using a secure, interactive electronic system when the office is not open.
PCMH 1B5	<ul style="list-style-type: none"> • Documenting after-hours clinical advice in patient records.
PCMH 1C	<ul style="list-style-type: none"> • Electronic access.
PCMH 1C4	<ul style="list-style-type: none"> • Two-way communication between patients/families and the practice.
PCMH 1C5	<ul style="list-style-type: none"> • Request for appointments or prescription refills.
PCMH 1C6	<ul style="list-style-type: none"> • Request for referrals or test results.
PCMH 1D	<ul style="list-style-type: none"> • Continuity.
PCMH 1D1	<ul style="list-style-type: none"> • Expecting patients/families to select a personal clinician.
PCMH 1D2	<ul style="list-style-type: none"> • Documenting the patient's/family's choice of clinician.

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ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME *(continued)*

REFERENCE	REQUIREMENTS
PCMH 1D3	<ul style="list-style-type: none"> Monitoring the percentage of patient visits with a selected clinician or team.
PCMH 1E	<ul style="list-style-type: none"> Medical home responsibilities.
PCMH 1E1	<ul style="list-style-type: none"> The practice is responsible for coordinating patient care across multiple settings.
PCMH 1E2	<ul style="list-style-type: none"> Instructions on obtaining care and clinical advice during office hours and when the office is closed.
PCMH 1E3	<ul style="list-style-type: none"> The practice functions most effectively as a medical home if patients/families provide a complete medical history and information about care obtained outside the practice.
PCMH 1E4	<ul style="list-style-type: none"> The care team gives the patient/family access to evidence-based care and self-management support.
PCMH 1F	<ul style="list-style-type: none"> Culturally and linguistically appropriate services.▲
PCMH 1F1	<ul style="list-style-type: none"> Assess the racial and ethnic diversity of its population.▲
PCMH 1F2	<ul style="list-style-type: none"> Assess the language needs of its population.▲
PCMH 1F3	<ul style="list-style-type: none"> Provide interpretation or bilingual services to meet the language needs of its population.▲
PCMH 1F4	<ul style="list-style-type: none"> Provide printed materials in the languages.▲
PCMH 1G	<ul style="list-style-type: none"> Practice organization.
PCMH 1G1	<ul style="list-style-type: none"> Defining roles for clinical and nonclinical members.
PCMH 1G2	<ul style="list-style-type: none"> Having regular team meetings and communications processes.
PCMH 1G3	<ul style="list-style-type: none"> Using standing orders for services.
PCMH 1G4	<ul style="list-style-type: none"> Training and assigning care teams to coordinate for individual patients.
PCMH 1G5	<ul style="list-style-type: none"> Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change.
PCMH 1G6	<ul style="list-style-type: none"> Training and assigning care teams for patient population management.
PCMH 1G7	<ul style="list-style-type: none"> Training and designating care team members in communication skills.
PCMH 1G8	<ul style="list-style-type: none"> Involving care team staff in the practice's performance evaluation and quality improvement activities.

PCMH = Patient-Centered Medical Home ▲ Requirement most directly relevant to issues of health equity.

PATIENT DATA

REFERENCE	REQUIREMENTS
PCMH 2A	<ul style="list-style-type: none"> Patient information. The practice uses an electronic system that records the following as structured (searchable) data for more than 50% of its patients:
PCMH 2A1	<ul style="list-style-type: none"> Date of birth.

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PATIENT DATA *(continued)*

REFERENCE	REQUIREMENTS
PCMH 2A2	<ul style="list-style-type: none"> • Gender.
PCMH 2A3	<ul style="list-style-type: none"> • Race.▲
PCMH 2A4	<ul style="list-style-type: none"> • Ethnicity.▲
PCMH 2A5	<ul style="list-style-type: none"> • Preferred language.▲
PCMH 2A6	<ul style="list-style-type: none"> • Telephone numbers.
PCMH 2A7	<ul style="list-style-type: none"> • Email addresses.
PCMH 2A8	<ul style="list-style-type: none"> • Dates of previous clinical visits.
PCMH 2A9	<ul style="list-style-type: none"> • Legal guardian/health care proxy.
PCMH 2A10	<ul style="list-style-type: none"> • Primary caregiver.
PCMH 2A12	<ul style="list-style-type: none"> • Health insurance information.
PCMH 2B	<ul style="list-style-type: none"> • Clinical data.
PCMH 2B2	<ul style="list-style-type: none"> • Allergies, including medication allergies and adverse reactions, for more than 80% of patients.
PCMH 2B3	<ul style="list-style-type: none"> • Blood pressure, with the date of update for more than 50% of patients.
PCMH 2B4	<ul style="list-style-type: none"> • Height for more than 50% of patients.
PCMH 2B5	<ul style="list-style-type: none"> • Weight for more than 50% of patients.
PCMH 2B6	<ul style="list-style-type: none"> • System calculates and displays BMI (not applicable for pediatric practices).
PCMH 2B7	<ul style="list-style-type: none"> • System plots and displays length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2-20 years) for more than 50% of pediatric patients, with the capability to plot changes over time.
PCMH 2B8	<ul style="list-style-type: none"> • Status of tobacco use for patients 13 years and older for more than 50% of patients.

PCMH = Patient-Centered Medical Home ▲ Requirement most directly relevant to issues of health equity.

MANAGING CARE

REFERENCE	REQUIREMENTS
PCMH 2C	<ul style="list-style-type: none"> • Comprehensive health assessment.
PCMH 2C1	<ul style="list-style-type: none"> • Documentation of age- and gender-appropriate immunizations and screenings.
PCMH 2C2	<ul style="list-style-type: none"> • Family/social/cultural characteristics.▲
PCMH 2C3	<ul style="list-style-type: none"> • Communication needs.▲

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MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
PCMH 2C4	<ul style="list-style-type: none"> • Medical history of patient and family.
PCMH 2C6	<ul style="list-style-type: none"> • Behaviors affecting health.
PCMH 2C7	<ul style="list-style-type: none"> • Patient and family mental health/substance abuse.
PCMH 2C8	<ul style="list-style-type: none"> • Developmental screening using a standardized tool (not applicable for adult-only practices).
PCMH 2C9	<ul style="list-style-type: none"> • Depression screening for adults and adolescents using a standardized tool.
PCMH 2D	<ul style="list-style-type: none"> • Using data for population management. The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for:
PCMH 2D1	<ul style="list-style-type: none"> • At least three different preventive care services.
PCMH 2D2	<ul style="list-style-type: none"> • At least three different chronic care services.
PCMH 2D3	<ul style="list-style-type: none"> • Patients not recently seen by the practice.
PCMH 2B	<ul style="list-style-type: none"> • Clinical data.
PCMH 2B1	<ul style="list-style-type: none"> • An up-to-date problem list with current and active diagnoses for more than 80% of patients.
PCMH 3A	<ul style="list-style-type: none"> • Implement evidence-based guidelines:
PCMH 3A1 and 3A2	<ul style="list-style-type: none"> • For two important conditions.
PCMH 3A3	<ul style="list-style-type: none"> • For a third condition, related to unhealthy behaviors or mental health or substance abuse.
PCMH 3B	<ul style="list-style-type: none"> • Identify high-risk patients.
PCMH 3B1	<ul style="list-style-type: none"> • Establishes criteria and a systematic process to identify high-risk or complex patients.
PCMH 3B2	<ul style="list-style-type: none"> • Determines the percentage of high-risk or complex patients.
PCMH 3C	<ul style="list-style-type: none"> • Manage care. The care team performs the following for at least 75% of the patients identified in Elements 3A and 3B:
PCMH 3C1	<ul style="list-style-type: none"> • Conducts pre-visit preparations.
PCMH 3C2	<ul style="list-style-type: none"> • Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit.
PCMH 3C3	<ul style="list-style-type: none"> • Gives the patient/family a written plan of care.
PCMH 3C4	<ul style="list-style-type: none"> • Assesses and addresses barriers when the patient has not met treatment goals.
PCMH 3C5	<ul style="list-style-type: none"> • Gives the patient/family a clinical summary at each relevant visit.
PCMH 3C6	<ul style="list-style-type: none"> • Identifies patients/families who might benefit from additional care management support.
PCMH 3C7	<ul style="list-style-type: none"> • Follows up with patients/families who have not kept important appointments.
PCMH 2A11	<ul style="list-style-type: none"> • Presence of advance directive.

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MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
PCMH 2C5	<ul style="list-style-type: none"> • Advance care planning (not applicable for pediatric practices).
PCMH 2B	<ul style="list-style-type: none"> • Clinical data.
PCMH 2B9	<ul style="list-style-type: none"> • List of prescription medications with the date of updates for more than 80% of patients.
PCMH 3D	<ul style="list-style-type: none"> • Manage medications.
PCMH 3D1	<ul style="list-style-type: none"> • Reviews and reconciles medications with patients/families for more than 50% of care transitions.
PCMH 3D2	<ul style="list-style-type: none"> • Reviews and reconciles medications with patients/families for more than 80% of care transitions.
PCMH 3D3	<ul style="list-style-type: none"> • Provides information about new prescriptions to more than 80% of patients/families.
PCMH 3D4	<ul style="list-style-type: none"> • Assesses patient/family understanding of medications for more than 50% of patients.
PCMH 3D5	<ul style="list-style-type: none"> • Assesses patient response to medications and barriers to adherence for more than 50% of patients.
PCMH 3D6	<ul style="list-style-type: none"> • Documents over-the-counter medications, herbal therapies, and supplements for more than 50% of patients/families, with the date of updates.
PCMH 3E	<ul style="list-style-type: none"> • Electronic prescribing.
PCMH 3E3	<ul style="list-style-type: none"> • Enters electronic medication orders into the medical record for more than 30% of patients with at least one medication in their medication list.
PCMH 3E1	<ul style="list-style-type: none"> • Generates and transmits at least 40% of eligible prescriptions to pharmacies.
PCMH 3E2	<ul style="list-style-type: none"> • Generates at least 75% of eligible prescriptions.
PCMH 3E4	<ul style="list-style-type: none"> • Performs patient-specific checks for drug-drug and drug-allergy interactions.
PCMH 3E6	<ul style="list-style-type: none"> • Alerts prescribers to formulary status.
PCMH 3E5	<ul style="list-style-type: none"> • Alerts prescribers to generic alternatives.
PCMH 4A	<ul style="list-style-type: none"> • Self-care process.
PCMH 4A2	<ul style="list-style-type: none"> • Uses an EHR to identify patient-specific education resources and provide them to more than 10% of patients, if appropriate.
PCMH 4A1	<ul style="list-style-type: none"> • Provides educational resources or refers at least 50% of patients/families to educational resources to assist in self-management.
PCMH 4A3	<ul style="list-style-type: none"> • Develops and documents self-management plans and goals in collaboration with at least 50% of patients/families.
PCMH 4A4	<ul style="list-style-type: none"> • Documents self-management abilities for at least 50% of patients/families.
PCMH 4A5	<ul style="list-style-type: none"> • Provides self-management tools to record self-care results for at least 50% of patients/families.
PCMH 4A6	<ul style="list-style-type: none"> • Counsels at least 50% of patients/families to adopt healthy behaviors.
PCMH 4B	<ul style="list-style-type: none"> • Referrals to community resources.
PCMH 4B1	<ul style="list-style-type: none"> • Maintains a current resource list on five topics or key community service areas of importance to the patient population. <i>(Continued)</i>

MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
PCMH 4B2	<ul style="list-style-type: none"> • Tracks referrals provided to patients/families.
PCMH 4B3	<ul style="list-style-type: none"> • Arranges or provides treatment for mental health and substance abuse disorders.
PCMH 4B4	<ul style="list-style-type: none"> • Offers opportunities for health education and peer support.

PCMH = Patient-Centered Medical Home

▲ Requirement most directly relevant to issues of health equity.

EHR = Electronic Health Record

COORDINATING CARE

REFERENCE	REQUIREMENTS
PCMH 5A	<ul style="list-style-type: none"> • Test tracking and follow-up.
PCMH 5A1	<ul style="list-style-type: none"> • Tracks lab tests until results are available, flagging and following up on overdue results.
PCMH 5A2	<ul style="list-style-type: none"> • Tracks imaging tests until results are available, flagging and following up on overdue results.
PCMH 5A3	<ul style="list-style-type: none"> • Flags abnormal lab results, bringing them to the attention of the clinician.
PCMH 5A4	<ul style="list-style-type: none"> • Flags abnormal imaging results, bringing them to the attention of the clinician.
PCMH 5A5	<ul style="list-style-type: none"> • Notifies patients/families of normal and abnormal lab and imaging results.
PCMH 5A6	<ul style="list-style-type: none"> • Follows up with inpatient facilities on newborn hearing and blood-spot screening (not applicable for adults).
PCMH 5A7	<ul style="list-style-type: none"> • Electronically communicates with labs to order tests and retrieve results.
PCMH 5A8	<ul style="list-style-type: none"> • Electronically communicates with facilities to order and retrieve imaging results.
PCMH 5A9	<ul style="list-style-type: none"> • Electronically incorporates at least 40% of all clinical lab results into structured fields in medical records.
PCMH 5A10	<ul style="list-style-type: none"> • Electronically incorporates imaging test results into medical records.
PCMH 5B	<ul style="list-style-type: none"> • Referral tracking and follow-up.
PCMH 5B1	<ul style="list-style-type: none"> • Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information.
PCMH 5B2	<ul style="list-style-type: none"> • Tracking the status of referrals including required time for receiving a specialist's report.
PCMH 5B3	<ul style="list-style-type: none"> • Following up to obtain a specialist's report.
PCMH 5B4	<ul style="list-style-type: none"> • Establishing and documenting agreements with specialists in the medical record if co-management is needed.
PCMH 5B5	<ul style="list-style-type: none"> • Asking patients/families about self-referrals and requesting reports from clinicians.
PCMH 5B6	<ul style="list-style-type: none"> • Demonstrating the capacity for electronic exchange of key clinical information (e.g. problem list, medication lists, allergies, diagnostic test results) between clinicians.
PCMH 5B7	<ul style="list-style-type: none"> • Providing an electronic summary of the care record for more than 50% of referrals.

(Continued)

COORDINATING CARE *(continued)*

REFERENCE	REQUIREMENTS
PCMH 5C	<ul style="list-style-type: none"> • Coordination with facilities/care transitions.
PCMH 5C1	<ul style="list-style-type: none"> • Demonstrates its process for identifying patients with a hospital admission or emergency department visit.
PCMH 5C2	<ul style="list-style-type: none"> • Demonstrates its process for sharing clinical information with the admitting hospital or emergency department.
PCMH 5C3	<ul style="list-style-type: none"> • Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities.
PCMH 5C4	<ul style="list-style-type: none"> • Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following hospital admission or emergency department visit.
PCMH 5C5	<ul style="list-style-type: none"> • Demonstrates its process for exchanging patient information with the hospital during a patient’s hospitalization.
PCMH 5C6	<ul style="list-style-type: none"> • Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (not applicable for adult-only practices).
PCMH 5C7	<ul style="list-style-type: none"> • Demonstrates the capacity for electronic exchange of key clinical information with facilities.
PCMH 5C8	<ul style="list-style-type: none"> • Provides an electronic summary-of-care record to another care facility for more than 50% of transitions of care.

PCMH = Patient-Centered Medical Home

SHARING INFORMATION WITH PATIENTS

REFERENCE	REQUIREMENTS
PCMH 1C	<ul style="list-style-type: none"> • Electronic access.
PCMH 1C3	<ul style="list-style-type: none"> • Clinical summaries are provided to patients for more than 50% of office visits within 3 business days.
PCMH 1C1	<ul style="list-style-type: none"> • More than 50% of patients who request an electronic copy of their health information receive it within 3 business days.
PCMH 1C2	<ul style="list-style-type: none"> • At least 10% of patients have electronic access to their health information within 4 business days of when the information is available to the practice.

PCMH = Patient-Centered Medical Home

IMPROVING QUALITY

REFERENCE	REQUIREMENTS
PCMH 6A	<ul style="list-style-type: none"> • Measure performance. The practice measures or receives data on the following:
PCMH 6A1	<ul style="list-style-type: none"> • At least three preventive care measures.
PCMH 6A2	<ul style="list-style-type: none"> • At least three chronic or acute care clinical measures.
PCMH 6A3	<ul style="list-style-type: none"> • At least two utilization measures affecting health care cost.

(Continued)

IMPROVING QUALITY *(continued)*

REFERENCE	REQUIREMENTS
PCMH 6A4	<ul style="list-style-type: none"> • Performance data stratified for vulnerable populations (to assess disparities in care).[▲]
PCMH 6C	<ul style="list-style-type: none"> • Implements continuous quality improvement.
PCMH 6C1	<ul style="list-style-type: none"> • Set goals and act to improve performance on at least 3 measures from Element 6A.
PCMH 6C2	<ul style="list-style-type: none"> • Set goals and act to improve performance on at least 1 measure from Element 6B.
PCMH 6C3	<ul style="list-style-type: none"> • Set goals and address at least one identified disparity in care or service for vulnerable populations.[▲]
PCMH 6C4	<ul style="list-style-type: none"> • Involve patients/families in quality improvement teams or on the practice’s advisory council.
PCMH 6D	<ul style="list-style-type: none"> • Demonstrates continuous quality improvement.
PCMH 6D1	<ul style="list-style-type: none"> • Tracking results over time.
PCMH 6D2	<ul style="list-style-type: none"> • Assessing the effect of its actions.
PCMH 6D3	<ul style="list-style-type: none"> • Achieving improved performance on one measure.
PCMH 6D4	<ul style="list-style-type: none"> • Achieving improved performance on a second measure.
PCMH 6E	<ul style="list-style-type: none"> • Performance reporting. The practice shares performance data from Element 6A and Element 6B.
PCMH 6E1	<ul style="list-style-type: none"> • Within the practice, results by individual clinician.
PCMH 6E2	<ul style="list-style-type: none"> • Within the practice, results across the practice.
PCMH 6E3	<ul style="list-style-type: none"> • Outside the practice to patients or publicly, results across the practice or by clinician.
PCMH 6F	<ul style="list-style-type: none"> • Report data externally. The practice electronically reports:
PCMH 6F1	<ul style="list-style-type: none"> • Ambulatory clinical quality measures to CMS.
PCMH 6F2	<ul style="list-style-type: none"> • Data to immunization registries or systems.
PCMH 6F3	<ul style="list-style-type: none"> • Syndromic surveillance data to public health agencies.
PCMH 6B	<ul style="list-style-type: none"> • Patient/family feedback.
PCMH 6B1	<ul style="list-style-type: none"> • The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: access, communication, coordination, whole-person care/self-management support.
PCMH 6B2	<ul style="list-style-type: none"> • The practice uses the Patient-Centered Medical Home version of the HCAHPS Clinician Group survey tool.
PCMH 6B3	<ul style="list-style-type: none"> • The practice obtains feedback in the experiences of vulnerable patient groups.[▲]
PCMH 6B4	<ul style="list-style-type: none"> • The practice obtains feedback from patients/families through qualitative means. Optional: Recognition in patient experience.

PCMH = Patient-Centered Medical Home

[▲] Requirement most directly relevant to issues of health equity.

CMS = Centers for Medicare and Medicaid Services

HCAHPS = Hospital Consumer Assessment of Healthcare Provider and Systems

Advancing Health Equity

Through national health care quality standards

National Committee for Quality Assurance (NCQA)

ACCOUNTABLE CARE ORGANIZATION

Reference: National Committee for Quality Assurance, Accountable Care Organization Accreditation Program (2011) can be found at: <http://www.ncqa.org/tabid/1312/default.aspx>

National Committee for Quality Assurance, Crosswalk ACO 2012 to PCMH 2011 (2011) Appendix 4, 2012 ACO Standards and Guidelines can be found at: <http://www.ncqa.org/tabid/1343/Default.aspx>



ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME

REFERENCE	REQUIREMENTS
PO 1B4	<ul style="list-style-type: none"> Stakeholders involved in oversight of ACO include consumers.
AA 1F5	<ul style="list-style-type: none"> The organization has a web-based clinician directory that includes the following information to help patients and prospective patients choose clinicians: languages spoken by the physician or clinical staff.
AA 1C1	<ul style="list-style-type: none"> The organization collects and performs an annual analysis of data to evaluate access to primary care practices for routine and urgent care appointments during office hours.
AA 1E1	<ul style="list-style-type: none"> The organization takes action to improve access or availability of practitioners providing primary care.
PC 2A	<ul style="list-style-type: none"> The organization evaluates the capacity of its participating primary care practices to meet NCQA ACO PCI requirements PCIA Access during office hours.
PC 1A1	<ul style="list-style-type: none"> Providing same-day appointments.
PC 1A2	<ul style="list-style-type: none"> Providing timely clinical advice by phone during office hours.
PC 1A3	<ul style="list-style-type: none"> Providing timely clinical advice by secure electronic messages during office hours.
AA 1D	<ul style="list-style-type: none"> The organization collects and performs an annual analysis of data to evaluate access to high-volume specialty care practitioners.
AA 1E2	<ul style="list-style-type: none"> The organization takes action to improve access or availability of high-volume specialty practitioners.
AA 1C2	<ul style="list-style-type: none"> The organization collects and performs an annual analysis of data to evaluate access to primary care practices for routine and urgent care appointments outside typical office hours.
PC 1B	<ul style="list-style-type: none"> After-hours access.
PC 1B1	<ul style="list-style-type: none"> Providing access to routine and urgent-care appointments outside regular business hours.
PC 1B2	<ul style="list-style-type: none"> Providing continuity of medical record information for care and advice when the office is not open.
PC 1B3	<ul style="list-style-type: none"> Providing timely clinical advice by telephone when the office is not open.
CM 4D	<ul style="list-style-type: none"> Electronic access for patients.

(Continued)

ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME *(continued)*

REFERENCE	REQUIREMENTS
CM 4D4	<ul style="list-style-type: none"> Two-way communication between patients/families and participating providers.
CM 4D5	<ul style="list-style-type: none"> Request for appointments or prescription refills.
CM 4D6	<ul style="list-style-type: none"> Request for referrals or test results.
PC 1K	<ul style="list-style-type: none"> Continuity.
PC 1K1	<ul style="list-style-type: none"> Expecting patients/families to select a personal clinician.
PC 1K2	<ul style="list-style-type: none"> Documenting the patient's/family's choice of clinician.
PC 1K3	<ul style="list-style-type: none"> Monitoring the percentage of patient visits with a selected clinician or team.
PC 1L	<ul style="list-style-type: none"> Medical home responsibilities.
PC 1L1	<ul style="list-style-type: none"> The practice is responsible for coordinating patient care across multiple settings.
PC 1L2	<ul style="list-style-type: none"> Instructions on obtaining care and clinical advice during office hours and when the office is closed.
PC 1L3	<ul style="list-style-type: none"> The practice functions most effectively as a medical home if parents/families provide a complete medical history and information about care obtained outside the practice.
PC 1L4	<ul style="list-style-type: none"> The care team gives the patient/family access to evidence-based care and self-management support.
RR 1A	<ul style="list-style-type: none"> ACO responsibilities.
RR 1A1	<ul style="list-style-type: none"> Distributes to patients information about the ACO, its services, the participating providers and patient rights and responsibilities.
RR 1A2	<ul style="list-style-type: none"> Distributes to patients information on the attribution method used to assign patients to the ACO and how patients may opt out.
RR 1A3	<ul style="list-style-type: none"> Instructions on obtaining care and clinical advice during practice office hours and after practice office hours, and information on hour of operation for practices in the ACO.
RR 1A4	<ul style="list-style-type: none"> Availability of health promotion information in languages relevant to the ACO's population. [▲]
RR 1B	<ul style="list-style-type: none"> Patient rights and responsibilities statement that includes:
RR 1B1	<ul style="list-style-type: none"> A right to be treated with respect and recognition of their dignity and their right to privacy.
RR 1B2	<ul style="list-style-type: none"> A right to participate with participating providers in making decisions about their health care.
RR 1B3	<ul style="list-style-type: none"> A right to receive complete information on treatment options.
RR 1B4	<ul style="list-style-type: none"> A right to voice complaints about the ACO or the care it provides.
RR 1B5	<ul style="list-style-type: none"> A responsibility to follow plans and instructions for care that they have agreed to with clinicians.
RR 1B6	<ul style="list-style-type: none"> A responsibility to participate in developing a care management plan and carrying it out.
PC 1C	<ul style="list-style-type: none"> The practice team.

(Continued)

ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME *(continued)*

REFERENCE	REQUIREMENTS
PC 1C1	<ul style="list-style-type: none"> Defining roles for clinical and nonclinical team members.
PC 1C2	<ul style="list-style-type: none"> Having regular team meetings and structured communication processes.
PC 1C3	<ul style="list-style-type: none"> Using standing orders for services.
PC 1C4	<ul style="list-style-type: none"> Training and assigning care teams to coordinate care for individual patients.
AA 1H	<ul style="list-style-type: none"> Access to culturally competent care. [▲]
AA 1H1	<ul style="list-style-type: none"> Analyzes the capacity of its practitioners to meet the language needs of its patients. [▲]
AA 1H2	<ul style="list-style-type: none"> Analyzes the capacity of its practitioners to meet the needs of its patients for culturally appropriate care. [▲]
AA 1H3	<ul style="list-style-type: none"> Develops a plan to address any gaps identified as a result of analysis, if applicable. [▲]
AA 1H4	<ul style="list-style-type: none"> Addresses gaps based on its plan, if applicable. [▲]

ACO = Accountable Care Organization NCQA = National Committee for Quality Assurance PC = Primary Care ▲ Requirement most directly relevant to issues of health equity.
 AA = Access and Availability RR = Patient Rights and Responsibilities CM = Care Management PO = Program Operations

PATIENT DATA

REFERENCE	REQUIREMENTS
CM 1A	<ul style="list-style-type: none"> Patient information. The organization uses an electronic system that records the following as structured (searchable) data for more than 50% of its patients:
CM 1A1	<ul style="list-style-type: none"> Date of birth.
CM 1A2	<ul style="list-style-type: none"> Gender.
CM 1A3	<ul style="list-style-type: none"> Race. [▲]
CM 1A4	<ul style="list-style-type: none"> Ethnicity. [▲]
CM 1A5	<ul style="list-style-type: none"> Preferred language. [▲]
CM 1A6	<ul style="list-style-type: none"> Telephone numbers.
CM 1A7	<ul style="list-style-type: none"> Email addresses.
CM 1A8	<ul style="list-style-type: none"> Dates of previous clinical visits.
CM 1A9	<ul style="list-style-type: none"> Legal guardian/health care proxy.
CM 1A10	<ul style="list-style-type: none"> Primary caregiver.
CM 1A12	<ul style="list-style-type: none"> Health insurance information.
CM 1B	<ul style="list-style-type: none"> Clinical data.

(Continued)

PATIENT DATA *(continued)*

REFERENCE	REQUIREMENTS
CM 1B2	<ul style="list-style-type: none"> Allergies, including medication allergies and adverse reactions, for more than 80% of patients.
CM 1B3	<ul style="list-style-type: none"> Blood pressure, with the date of update for more than 50% of patients.
CM 1B4	<ul style="list-style-type: none"> Height for more than 50% of patients.
CM 1B5	<ul style="list-style-type: none"> Weight for more than 50% of patients.
CM 1B8	<ul style="list-style-type: none"> Status of tobacco use for patients 13 years and older for more than 50% of patients.

CM = Care Management

▲ Requirement most directly relevant to issues of health equity.

MANAGING CARE

REFERENCE	REQUIREMENTS
CM 2A	<ul style="list-style-type: none"> Administers health appraisal to new patients within 90 days of assignment.
CM 3A	<ul style="list-style-type: none"> Identifying care needs.
CM 3A1	<ul style="list-style-type: none"> Wellness and health promotion programs.
CM 3A2	<ul style="list-style-type: none"> Chronic disease management programs.
CM 3A3	<ul style="list-style-type: none"> Complex case management.
CM 4A	<ul style="list-style-type: none"> Patient care registries.
CM 4A1-3	<ul style="list-style-type: none"> For three preventive care services.
CM 4A4-6	<ul style="list-style-type: none"> For three chronic or acute care conditions.
CM 3B	<ul style="list-style-type: none"> Providing population health management.
CM 3B1	<ul style="list-style-type: none"> Wellness and health promotion programs.
CM 3B2	<ul style="list-style-type: none"> Chronic disease management programs.
CM 3B3	<ul style="list-style-type: none"> Complex case management.
CM 1B	<ul style="list-style-type: none"> Clinical data.
CM 1B1	<ul style="list-style-type: none"> An up-to-date problem list with current and active diagnoses for more than 80% of patients.
PC 1D	<ul style="list-style-type: none"> Implement evidence-based guidelines.
PC 1D1. and PC 1D2	<ul style="list-style-type: none"> For two important conditions.
PC 1D3	<ul style="list-style-type: none"> A third condition must be related to unhealthy behaviors or mental health or substance abuse.

(Continued)

MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
PC 1D4	<ul style="list-style-type: none"> • A high-risk or complex condition.
PO 2A	<ul style="list-style-type: none"> • Adopts evidence-based guidelines and disseminates decision support tools to participating providers for:
PO 2A1	<ul style="list-style-type: none"> • At least one important chronic condition.
PO 2A2	<ul style="list-style-type: none"> • At least one high-risk or complex condition.
PO 2A3	<ul style="list-style-type: none"> • At least one condition related to unhealthy behaviors or mental health or substance abuse.
PC 1E	<ul style="list-style-type: none"> • Care management. The care team performs the following for at least 75% of the patients identified in Elements PC 1D:
PC 1E1	<ul style="list-style-type: none"> • Conducts pre-visit preparations.
PC 1E2	<ul style="list-style-type: none"> • Collaborates with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit.
PC 3C3	<ul style="list-style-type: none"> • Gives the patient/family a written plan of care.
PC 3C4	<ul style="list-style-type: none"> • Assesses and addresses barriers when the patient has not met treatment goals.
PC 3C5	<ul style="list-style-type: none"> • Gives the patient/family a clinical summary at each relevant visit.
PC 3C6	<ul style="list-style-type: none"> • Identifies patients/families who might benefit from additional care management support.
PC 3C7	<ul style="list-style-type: none"> • Follows up with patients/families who have not kept important appointments.
CM 1B	<ul style="list-style-type: none"> • Clinical data.
CM 1B7	<ul style="list-style-type: none"> • List of prescription medications with the date of updates for more than 80% of patients.
PC 1F	<ul style="list-style-type: none"> • Medication management.
PC 1F1	<ul style="list-style-type: none"> • Reviews and reconciles medications with patients/families for more than 50% of care transitions.
PC 1F2	<ul style="list-style-type: none"> • Provides information about new prescriptions to more than 80% of patients/families.
PC 1F3	<ul style="list-style-type: none"> • Assesses patient response to medications and barriers to adherence for more than 50% of patients.
CM 4B	<ul style="list-style-type: none"> • Electronic prescribing.
CM 4B3	<ul style="list-style-type: none"> • Enters electronic medication orders into the medical record for more than 30% of patients with at least one medication in their medication list.
CM 4B1	<ul style="list-style-type: none"> • Generates and transmits at least 40% of eligible prescriptions to pharmacies.
CM 4B2	<ul style="list-style-type: none"> • Generates at least 75% of eligible prescriptions.
CM 4B4	<ul style="list-style-type: none"> • Performs patient-specific checks for drug-drug and drug-allergy interactions.
CM 4B6	<ul style="list-style-type: none"> • Alerts prescribers to formulary status.
CM 4B5	<ul style="list-style-type: none"> • Alerts prescribers to generic alternatives.

(Continued)

MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
PC 1G1	<ul style="list-style-type: none"> Documents self-management abilities for at least 50% of patients/families.
PC 1G2	<ul style="list-style-type: none"> Develops and documents self-management plans and goals in collaboration with at least 50% of patients/families.
PC 1G3	<ul style="list-style-type: none"> Provides educational resources or refers at least 50% of patients/families to educational resources to assist in self-management factors.
PC 1G4	<ul style="list-style-type: none"> Uses an EHR to identify patient-specific educational resources and provide them to more than 10% of patients, if appropriate.
CM 4C	<ul style="list-style-type: none"> Self-management support.
CM 4C1	<ul style="list-style-type: none"> Provides educational resources to assist in self-management.
CM 4C2	<ul style="list-style-type: none"> Provides self-management tools that enable patients/families to record self-care results.
CM 4C3	<ul style="list-style-type: none"> Provides or connects patients/families to self-management support programs and resources.

CM = Care Management PC = Primary Care EHR = Electronic Health Record PO = Program Operations

COORDINATING CARE

REFERENCE	REQUIREMENTS
PC 1H	<ul style="list-style-type: none"> Test tracking and follow-up.
PC 1H1	<ul style="list-style-type: none"> Tracks lab tests until results are available, flagging and following up on overdue results.
PC 1H2	<ul style="list-style-type: none"> Tracks imaging tests until results are available, flagging and following up on overdue results.
PC 1H3	<ul style="list-style-type: none"> Flags abnormal lab results, bringing them to the attention of the clinician.
PC 1H4	<ul style="list-style-type: none"> Flags abnormal imaging results, bringing them to the attention of the clinician.
PC 1H5	<ul style="list-style-type: none"> Notifies patients/families of normal and abnormal lab and imaging results.
CM 1B8	<ul style="list-style-type: none"> Electronically incorporates at least 40% of all clinical lab results into structured fields in medical records.
PC 1I	<ul style="list-style-type: none"> Referral tracking and follow-up.
PC 1I1	<ul style="list-style-type: none"> Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information.
PC 1I2	<ul style="list-style-type: none"> Tracking the status of referrals including required timing for receiving a specialist's report.
PC 1I3	<ul style="list-style-type: none"> Following up to obtain a specialist's report.
CM 1C	<ul style="list-style-type: none"> Participating provider access to electronic data.
CM 1D	<ul style="list-style-type: none"> Health information exchange.
CM 1E	<ul style="list-style-type: none"> Process for data collection and integration.

(Continued)

COORDINATING CARE *(continued)*

REFERENCE	REQUIREMENTS
CM 1F	<ul style="list-style-type: none"> Data collection and integration.
CM 1G	<ul style="list-style-type: none"> Use of data for identifying patient needs, care management, and performance measurement.
CM 1H	<ul style="list-style-type: none"> Data completeness.
CT 1A	<ul style="list-style-type: none"> Coordinating information exchange.
CT 1B	<ul style="list-style-type: none"> Process for transitions.
CT 1B1	<ul style="list-style-type: none"> Identify patients who transition between settings.
CT 1B2	<ul style="list-style-type: none"> Share clinical information received from the first setting with the second setting and the primary care practitioner.
CT 1B3	<ul style="list-style-type: none"> Communicate with hospitals to exchange information about patients during hospitalization.
CT 1B4	<ul style="list-style-type: none"> Obtain patient discharge summaries from hospitals, emergency departments and other facilities.
CT 1B5	<ul style="list-style-type: none"> Contact patients or families following transitions within an appropriate time frame for appropriate follow-up care.
CT 1B6	<ul style="list-style-type: none"> Electronically exchange key clinical information with facilities.
CT 1B7	<ul style="list-style-type: none"> Provide an electronic summary of care to other care settings.
CT 1B8	<ul style="list-style-type: none"> Track the status of transitions, including the timing of information exchange.
CT 1D	<ul style="list-style-type: none"> The organization has a process to determine whether timely information exchange occurred between providers for care coordination and care transitions.
CT 1C	<ul style="list-style-type: none"> The organization demonstrates that the transitioning or referring practitioner provides a summary of care record for more than 50% of transitions of care and referrals.
CT 1E	<ul style="list-style-type: none"> Safe transitions (reviewed at least quarterly).
CT 1E1	<ul style="list-style-type: none"> The sending setting's care plan was shared with the receiving setting within a specified time frame.
CT 1E2	<ul style="list-style-type: none"> The patient's usual practitioner was notified of the transition within a specified time.
CT 1E3	<ul style="list-style-type: none"> Communication with the patient or the patient's family about the care transition process occurred within a specified time frame.
CT 1E4	<ul style="list-style-type: none"> Communication with the patient or the patient's family about changes to the patient's health status and plan of care occurred within a specified time frame.

CM = Care Management CT = Care Coordination and Transitions PC = Primary Care

SHARING INFORMATION WITH PATIENTS

REFERENCE	REQUIREMENTS
CM 4D	<ul style="list-style-type: none"> Electronic access for patients.

(Continued)

SHARING INFORMATION WITH PATIENTS *(continued)*

REFERENCE	REQUIREMENTS
CM 4D3	<ul style="list-style-type: none"> Clinical summaries are provided to patients for more than 50% of office visits within 3 business days.
CM 4D1	<ul style="list-style-type: none"> More than 50% of patients who request an electronic copy of their health information receive it within 3 business days.
CM 4D2	<ul style="list-style-type: none"> At least 10% of patients have electronic access to their health information within 4 business days of when the information is available to the practice.
RR 1C	<ul style="list-style-type: none"> Written policies for privacy and confidentiality address access, use, and disclosure of personal health information.
RR 1D	<ul style="list-style-type: none"> ACO-wide process for managing physical and electronic access to sensitive information.

CM = Care Management RR = Patient Rights and Responsibilities ACO = Accountable Care Organization

IMPROVING QUALITY

REFERENCE	REQUIREMENTS
PR 1A	<ul style="list-style-type: none"> At least annually, monitors core performance measures.
PR 2D	<ul style="list-style-type: none"> Use of data to assess disparities.▲
PR 2D1	<ul style="list-style-type: none"> Analyze one or more valid measures of clinical performance, such as HEDIS, by race/ethnicity.▲
PR 2D2	<ul style="list-style-type: none"> Analyze one or more valid measures of clinical performance, such as HEDIS, by language.▲
PR 2D3	<ul style="list-style-type: none"> Analyze one or more valid measures of eligible individual experience, such as HCAHPS, by race/ethnicity or language.▲
PR 2E	<ul style="list-style-type: none"> Addressing health care disparities.▲
PR 2E1	<ul style="list-style-type: none"> Identifies and prioritizes opportunities to reduce health care disparities.▲
PR 2E2	<ul style="list-style-type: none"> Implements at least one intervention to address a disparity.▲
PR 2E3	<ul style="list-style-type: none"> Evaluates the effectiveness of the intervention.▲
PC 1J	<ul style="list-style-type: none"> Implements continuous quality improvement.
PC 1J1	<ul style="list-style-type: none"> Set goals and act to improve on at least three measures of clinical performance.
PC 1J2	<ul style="list-style-type: none"> Set goals and act to improve on at least one measure of patient/family experience.
PR 2A	<ul style="list-style-type: none"> Clinical quality improvement.
PR 2A1	<ul style="list-style-type: none"> Conducts a quantitative analysis of performance, including comparison with a benchmark or goal using clinical data.
PR 2A2	<ul style="list-style-type: none"> Conducts a qualitative analysis of performance using clinical quality data.
PR 2A3	<ul style="list-style-type: none"> Identifies at least three opportunities for improvement.
PR 2A4	<ul style="list-style-type: none"> Implements interventions to improve selected opportunities.

(Continued)

IMPROVING QUALITY (continued)

REFERENCE	REQUIREMENTS
PR 2A5	<ul style="list-style-type: none"> Measures the effectiveness of interventions to improve the overall clinical impact.
PR 1C	<ul style="list-style-type: none"> Practice performance reporting (at least quarterly).
PR 1C1	<ul style="list-style-type: none"> Distributes practice-level or clinician-level performance reports to primary care practitioners.
PR 1C2	<ul style="list-style-type: none"> Distributes practice-level or clinician-level performance reports to high-volume specialty care practitioners.
PR 1C3	<ul style="list-style-type: none"> Distributes reports to participating providers on the performance of other practitioners, for referrals.
PR 1C4	<ul style="list-style-type: none"> Has a documented process for addressing practitioner requests to review and correct data in performance reports.
PO 2D1	<ul style="list-style-type: none"> The organization provides performance reports to participating providers that detail variation in care patterns.
PO 2D2	<ul style="list-style-type: none"> The organization provides training and education on reducing variation to clinicians.
PR 1D	<ul style="list-style-type: none"> Publicly report performance on clinical quality, patient experience, and expenditures (at least annually).
PR 1B	<ul style="list-style-type: none"> Patient experience measures.
PR 1B1	<ul style="list-style-type: none"> At least annually, ACO monitors patient experience using HCAHPS clinician group survey data.
PR 1B2	<ul style="list-style-type: none"> At least annually, ACO monitors patient experience using HCAHPS survey data, if applicable.
PR 2C	<ul style="list-style-type: none"> Patient experience improvement.
PR 2C1	<ul style="list-style-type: none"> Conducts a quantitative analysis of patient experience results including comparison with a benchmark or goal.
PR 2C2	<ul style="list-style-type: none"> Conducts a qualitative analysis.
PR 2C3	<ul style="list-style-type: none"> Identifies at least three opportunities for improvement.
PR 2C4	<ul style="list-style-type: none"> Implements interventions to improve selected opportunities.
PR 2C5	<ul style="list-style-type: none"> Measures the effectiveness of interventions to improve selected patient experience opportunities.
RR 1E	<ul style="list-style-type: none"> Written policies and procedures for patient complaints.
PO 2C2	<ul style="list-style-type: none"> The organization identifies and monitors complaints and the results of patient satisfaction surveys to determine if patients feel they are receiving needed care.
PO 2C1	<ul style="list-style-type: none"> The organization identifies and monitors at least three practice patterns for excessive utilization, appropriateness of care or activities that waste resources.
PR 2B	<ul style="list-style-type: none"> Cost performance improvement.
PR 2B1	<ul style="list-style-type: none"> Conducts a quantitative analysis of performance, including comparison with a benchmark or goal using cost data.
PR 2B2	<ul style="list-style-type: none"> Conducts a qualitative analysis of performance using cost data.
PR 2B3	<ul style="list-style-type: none"> Identifies at least three opportunities for improvement.
PR 2B4	<ul style="list-style-type: none"> Implements interventions to improve selected opportunities.
PR 2B5	<ul style="list-style-type: none"> Measures the effectiveness of interventions to improve the overall cost impact.

Advancing Health Equity

Through national health care quality standards

National Committee for Quality Assurance (NCQA)

DISTINCTION IN MULTICULTURAL HEALTH CARE

Reference: National Committee for Quality Assurance, *Distinction in Multicultural Health Care (2010)* can be found at:

<http://www.ncqa.org/tabid/1157/Default.aspx>



ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME

REFERENCE	REQUIREMENTS
MHC 2	<ul style="list-style-type: none"> • Access and availability of language services. ▲
MHC 2A	<ul style="list-style-type: none"> • Written documents. ▲
MHC 2B	<ul style="list-style-type: none"> • Spoken language services. ▲
MHC 2C	<ul style="list-style-type: none"> • Support for language services. ▲
MHC 2D	<ul style="list-style-type: none"> • Notification of language services. ▲
MHC 4	<ul style="list-style-type: none"> • Culturally and linguistically appropriate services program. ▲
MHC 4A	<ul style="list-style-type: none"> • Program description. ▲
MHC 4B	<ul style="list-style-type: none"> • Annual evaluation. ▲
MHC 3	<ul style="list-style-type: none"> • Practitioner network cultural responsiveness. ▲
MHC 3A	<ul style="list-style-type: none"> • Assessment and availability of information. ▲
MHC 3B	<ul style="list-style-type: none"> • Enhancing network responsiveness. ▲

MHC = Multicultural Health Care ▲ Requirement most directly relevant to issues of health equity.

PATIENT DATA

REFERENCE	REQUIREMENTS
MHC 1	<ul style="list-style-type: none"> • Race/ethnicity and language data. ▲
MHC 1A	<ul style="list-style-type: none"> • Collection of data on race/ethnicity. ▲

(Continued)

PATIENT DATA *(continued)*

REFERENCE	REQUIREMENTS
MHC 1B	<ul style="list-style-type: none"> • Collection of data on language.[▲]
MHC 1C	<ul style="list-style-type: none"> • Privacy protections for race/ethnicity/language data.[▲]
MHC 1D	<ul style="list-style-type: none"> • Notification of privacy protections.[▲]

MHC = Multicultural Health Care ▲ Requirement most directly relevant to issues of health equity.

IMPROVING QUALITY

REFERENCE	REQUIREMENTS
MHC 5	<ul style="list-style-type: none"> • Reducing health care disparities.[▲]
MHC 5A	<ul style="list-style-type: none"> • Use of data to assess disparities.[▲]
MHC 5B	<ul style="list-style-type: none"> • Use of data to monitor and assess services.[▲]
MHC 5C	<ul style="list-style-type: none"> • Use of data to measure culturally and linguistically appropriate services and disparities.[▲]

MHC = Multicultural Health Care ▲ Requirement most directly relevant to issues of health equity.

Advancing Health Equity

Through national health care quality standards

ADDITIONAL OPPORTUNITIES TO ADVANCE HEALTH EQUITY

Reference: National Quality Forum, **Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competence (2009)** can be found at:

http://www.qualityforum.org/projects/cultural_competency.aspx



ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME

REFERENCE	REQUIREMENTS
NQF Preferred Practice 1	<ul style="list-style-type: none"> • Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
NQF Preferred Practice 3	<ul style="list-style-type: none"> • Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
NQF Preferred Practice 5	<ul style="list-style-type: none"> • Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
NQF Preferred Practice 5	<ul style="list-style-type: none"> • Include consumers from diverse backgrounds in consumer representation on oversight and governance bodies.
NQF Preferred Practice 5	<ul style="list-style-type: none"> • Provide proactive assistance with eligibility, enrollment, and retention in public insurance, drug assistance, and other programs for underserved populations.
NQF Preferred Practice 5	<ul style="list-style-type: none"> • Work with state health insurance exchanges to ensure seamless enrollment in health insurance coverage, selection of a primary care provider, and establishment of a medical home.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • If requested by the patient, provide resources such as provider directories that indicate the languages providers speak, so that patients can have access to this information.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Distinguish between languages spoken by the physician/clinician and languages spoken by other staff in provider directories.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Assess physician and staff language proficiency (ability to communicate effectively in the language during a medical encounter).
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Expand services available during evening/weekend hours.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Analyze provider network for sufficiency of language access.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Provide language assistance services during after-hours access.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Provide multilingual patient Internet portals, with bi-directional multilingual communications enabled, and address literacy and disability access issues.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Family-based practice.

(Continued)

ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME *(continued)*

REFERENCE	REQUIREMENTS
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Allow all members of family to select same personal clinician, if appropriate.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Proactively assist with health insurance and other service eligibility and coverage for entire family.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Explain medical home in culturally and linguistically appropriate way.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Obtain agreement to participate in medical home from patient/family/caregivers.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Ensure that all patient consents and authorizations are culturally and linguistically appropriate and are in multiple, accessible formats.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Explain ACO in culturally and linguistically appropriate way.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Obtain agreement to participate in ACO from patient/family/caregivers.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Ensure that all patient consents and authorizations are culturally and linguistically appropriate and are in multiple, accessible formats.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Provide notice of right to language assistance services.
NQF Preferred Practice 22	<ul style="list-style-type: none"> • Explain how to file complaints about lack of language access or delays or denials of care due to language barriers.
NQF Preferred Practice 6	<ul style="list-style-type: none"> • Commit to cultural competency through systemwide approaches that are articulated through written policies, practices, procedures, and programs.
NQF Preferred Practice 8	<ul style="list-style-type: none"> • Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.
NQF Preferred Practice 33	<ul style="list-style-type: none"> • Utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating the effectiveness of cultural competency activities.
NQF Preferred Practice 39	<ul style="list-style-type: none"> • Maintain a current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement services that respond to the cultural characteristics of the service area.
NQF Preferred Practice 38	<ul style="list-style-type: none"> • Utilize indirect data collection methodologies (e.g., geocoding, surname analysis) to characterize the race, ethnicity, and primary written and spoken language of a community for service planning and conducting community-based targeted interventions.
NQF Preferred Practice 13	<ul style="list-style-type: none"> • Determine and document the linguistic needs of a patient or legal guardian at first points of contact, and periodically assess them throughout the health care experience.
NQF Preferred Practice 12	<ul style="list-style-type: none"> • Offer and provide language access resources in the patient’s primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
NQF Preferred Practice 14	<ul style="list-style-type: none"> • Maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, such as competent bilingual or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.
NQF Preferred Practice 15	<ul style="list-style-type: none"> • Translate all vital documents, at a minimum, into the identified threshold languages for the community that is eligible to be served.
NQF Preferred Practice 16	<ul style="list-style-type: none"> • Translate written materials that are not considered vital when it is determined that a printed translation is needed for effective communication.
NQF Preferred Practice 17	<ul style="list-style-type: none"> • Ensure that a qualified interpreter reads a document to a patient if the patient cannot read the translated document. <i>(Continued)</i>

ESTABLISHMENT OF MEDICAL HOME/ACCESS TO MEDICAL HOME *(continued)*

REFERENCE	REQUIREMENTS
NQF Preferred Practice 9	<ul style="list-style-type: none"> • Implement language access planning in any area where care is delivered.
NQF Preferred Practice 9	<ul style="list-style-type: none"> • Use professional or certified health care interpreters.
NQF Preferred Practice 9	<ul style="list-style-type: none"> • Provide and support assessment, training, certification, and continuing education of health care interpreters.
NQF Preferred Practice 9	<ul style="list-style-type: none"> • Use professional translation services with quality assurance mechanisms.
NQF Preferred Practice 18	<ul style="list-style-type: none"> • Use “teach back” as a patient engagement tool to enhance communication between the health care provider and the patient during clinical encounters.
NQF Preferred Practice 4	<ul style="list-style-type: none"> • Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
NQF Preferred Practice 28	<ul style="list-style-type: none"> • Recruit and hire ethnically diverse providers and staff at all levels, including management levels.
NQF Preferred Practice 29	<ul style="list-style-type: none"> • Actively promote the retention of a culturally diverse workforce through organizational policies and programs.
NQF Preferred Practice 30	<ul style="list-style-type: none"> • Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and promptly and equitably resolving cross-cultural conflicts or complaints by patients or between organizational staff.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Use community health workers and patient navigators as part of care team.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Implement strategies to recruit/retain health workforce from local community.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Conduct ongoing staff training on cultural competency, language access, and disparities.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Include diverse patient advisors in staff training.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Include reduction of disparities in individual and organizational performance measures, recognition, and incentives/rewards.
NQF Preferred Practice 45	<ul style="list-style-type: none"> • Adopt organizational role as advocate for patients/communities.

NQF = National Quality Forum

ACO = Accountable Care Organization

PATIENT DATA

REFERENCE	REQUIREMENTS
NQF Preferred Practice 36	<ul style="list-style-type: none"> • Utilize the Health Research & Educational Trust (HRET) Disparities Toolkit to collect patient race/ethnicity and primary written and spoken language data from patients in a systematic, uniform manner.
NQF Preferred Practice 37	<ul style="list-style-type: none"> • Ensure that, at a minimum, data on an individual patient’s race and ethnicity (using the Office of Management and Budget categories as modified by HRET) and primary written and spoken language are collected in health records and integrated into the organization’s management information systems; periodically update the language information.
NQF Preferred Practice 37	<ul style="list-style-type: none"> • Collect granular ethnicity data.

(Continued)

PATIENT DATA *(continued)*

REFERENCE	REQUIREMENTS
NQF Preferred Practice 37	<ul style="list-style-type: none"> • Collect additional patient demographics (disability, sexual orientation, gender identity, health literacy, education, income, etc.).
NQF Preferred Practice 37	<ul style="list-style-type: none"> • All registries and clinical data are stratified by race, ethnicity, language and other patient demographics to identify and monitor reduction of disparities.

NQF = National Quality Forum

HRET = Health Research & Educational Trust

MANAGING CARE

REFERENCE	REQUIREMENTS
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Assess and improve patient- and family-centered communication on an ongoing basis.
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Conduct comprehensive health assessment at intake/first visit.
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Use community health workers for health education/promotion and disease prevention.
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Incorporate complementary and alternative medicine/integrative medicine in health assessment and care plans.
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Send culturally and linguistically appropriate communications/reminders to patients in multiple, accessible formats.
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Reference and consider race, ethnicity, language and other demographic data in clinical decision support.
NQF Preferred Practice 43	<ul style="list-style-type: none"> • Develop and use best practice clinical guidelines for conditions more prevalent in specific populations, e.g. Hep B, sickle cell disease.
NQF Preferred Practice 23	<ul style="list-style-type: none"> • Develop and implement a comprehensive care plan that addresses cultural concerns.
NQF Preferred Practice 21	<ul style="list-style-type: none"> • Include family members in health care decisions, when requested by the patient, when providing care for culturally diverse populations.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Consider cultural, spiritual, and religious beliefs that may complement or conflict with standard medical care.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Develop and use culturally and linguistically appropriate group visit protocols and other peer-based care management support.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Develop and use culturally and linguistically appropriate shared decision-making tools in multiple, accessible formats.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Provide enabling services such as interpreter services, transportation, case management, etc.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Use culturally and linguistically appropriate advance directives in multiple, accessible formats.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Formalize collaboration with community pharmacists on quality improvement.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Make medication lists and instructions available to patient/family/caregivers in multiple, accessible formats and conduct medication reconciliation with language assistance.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Ensure electronic prescriptions identify, and pharmacies address, language needs.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Assist patients with formulary and medication payment issues.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Facilitate linkages with drug assistance programs.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Provide culturally and linguistically appropriate health education materials in multiple, accessible formats. <i>(Continued)</i>

MANAGING CARE *(continued)*

REFERENCE	REQUIREMENTS
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Use community health workers, patient navigators and other peer approaches to health promotion and health education.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Develop and use culturally and linguistically appropriate patient self-management tools in multiple, accessible formats.
NQF Preferred Practice 24	<ul style="list-style-type: none"> • Develop and use culturally and linguistically appropriate patient self-management support tools in multiple, accessible formats for family/caregivers.
NQF Preferred Practice 32	<ul style="list-style-type: none"> • Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
NQF Preferred Practice 31	<ul style="list-style-type: none"> • Engage communities to ensure that health care providers (individual and organizational) are aware of current and changing patient populations and cultural and communication needs, and provide opportunities to share resources and information.
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Health care professionals and organizations should engage communities in building their assets as vehicles for improving health outcomes.
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Has strong linkages to culturally and linguistically appropriate community resources.
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Has linkages to school-based and school-linked sites for adolescent health services.
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Execute formal referral agreements with health education, nutrition, exercise, peer support, family-to-family support, home health, adult day health, rehabilitation, preschool, school-based and linked health, afterschool, child care, transportation, legal, and other programs and support services.
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Continuous advocacy with local/state health, social services, aging departments and with school districts, etc. for culturally and linguistically appropriate services for patients, families, and communities.

NQF = National Quality Forum

COORDINATING CARE

REFERENCE	REQUIREMENTS
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Ensure test results are available in multiple languages and formats, or with interpreter services.
NQF Preferred Practice 34	<ul style="list-style-type: none"> • Ensure labs and diagnostic test facilities are aware of and address language needs.
NQF Preferred Practice 26	<ul style="list-style-type: none"> • Use culturally appropriate care coordination services that take into consideration the cultural diversity of the populations seeking health care.
NQF Preferred Practice 26	<ul style="list-style-type: none"> • Ensure referred specialists are aware of and address language needs.
NQF Preferred Practice 26	<ul style="list-style-type: none"> • Provide enabling services for care coordination.
NQF Preferred Practice 26	<ul style="list-style-type: none"> • Provide care coordination documents in formats that address literacy and disabilities, and are available in multiple languages.
NQF Preferred Practice 26	<ul style="list-style-type: none"> • Ensure referred providers are aware of and address language needs. <i>(Continued)</i>

NQF = National Quality Forum

SHARING INFORMATION WITH PATIENTS

REFERENCE	REQUIREMENTS
NQF Preferred Practice 27	<ul style="list-style-type: none"> Explore, evaluate, and consider the use of multimedia approaches and health information technology to enable the provision of health care services that are patient- and family-centered and culturally tailored to the patient.
NQF Preferred Practice 27	<ul style="list-style-type: none"> Provide clinical summaries and other health information in multiple formats that address literacy and disabilities, and are available in multiple languages.
NQF Preferred Practice 27	<ul style="list-style-type: none"> Provide multilingual patient Internet portal.
NQF Preferred Practice 27	<ul style="list-style-type: none"> Use mobile phone and other mobile devices for bi-directional communications and access to electronic health information.
NQF Preferred Practice 27	<ul style="list-style-type: none"> Make personal health information available in multiple languages and formats.
NQF Preferred Practice 27	<ul style="list-style-type: none"> Ensure that patients understand and consent to uses of electronic health information through a culturally and linguistically appropriate consent process.

NQF = National Quality Forum

IMPROVING QUALITY

REFERENCE	REQUIREMENTS
NQF Preferred Practice 40	<ul style="list-style-type: none"> Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.
NQF Preferred Practice 40	<ul style="list-style-type: none"> Stratify all quality reports by race, ethnicity, language and other patient demographics to identify and address disparities.
NQF Preferred Practice 40	<ul style="list-style-type: none"> Implement quality improvement action plans to reduce identified disparities.
NQF Preferred Practice 40	<ul style="list-style-type: none"> Collaborate with patient advisors from diverse backgrounds on quality improvement.
NQF Preferred Practice 40	<ul style="list-style-type: none"> Choose quality improvement goals that also reduce disparities.
NQF Preferred Practice 41	<ul style="list-style-type: none"> Publicly report data for applicable NQF-endorsed disparities-sensitive national voluntary consensus standards for ambulatory care stratified by race and ethnicity and primary written and spoken language.
NQF Preferred Practice 42	<ul style="list-style-type: none"> Regularly make available to the public information about progress and successful innovations in implementing culturally competent programs (especially the NQF-endorsed preferred practices for cultural competency), and provide public notice in communities about the availability of this information.
NQF Preferred Practice 42	<ul style="list-style-type: none"> Stratify all quality performance reports by race, ethnicity, language, and other patient demographics.
NQF Preferred Practice 42	<ul style="list-style-type: none"> Provide training and education to clinicians and staff on reducing disparities.
NQF Preferred Practice 44	<ul style="list-style-type: none"> Any surveys created by or conducted by the organization must collect race, ethnicity, and primary written and spoken language, and analysis and results must be stratified by race, ethnicity, and primary written and spoken language.
NQF Preferred Practice 44	<ul style="list-style-type: none"> Conduct patient experience surveys in multiple languages and formats.
NQF Preferred Practice 44	<ul style="list-style-type: none"> Have patient council or advisory body.
NQF Preferred Practice 44	<ul style="list-style-type: none"> Use focus groups and other culturally appropriate data collection about patient/family/caregiver experience.
NQF Preferred Practice 44	<ul style="list-style-type: none"> Ensure that immunization data reported electronically is stratified by race, ethnicity, language and other patient demographics.
NQF Preferred Practice 44	<ul style="list-style-type: none"> Ensure that public health data reported electronically is stratified by race, ethnicity, language and other patient demographics.

NQF = National Quality Forum

ABOUT THE AUTHOR



Ignatius Bau

Ignatius Bau is an independent health policy consultant, working with organizations including the California Pan-Ethnic Health Network, Consumers Union, National Partnership for Women & Families, National Council of Asian & Pacific Islander Physicians, Association of Asian Pacific Community Health Organizations, and Asian & Pacific Islander American Health Forum. He previously worked at The California Endowment, managing the foundation's work on language access, cultural competency, health care disparities, health workforce diversity, and health information technology. He has served on expert advisory groups for the Institute of Medicine, National Quality Forum, Joint Commission, Office of Minority Health, Office of National Coordinator for Health Information Technology, Centers for Disease Control and Prevention, and California Department of Health Services. He also has served on the boards of directors of Cal eConnect, Funders for Lesbian, Gay, Bisexual, Transgender Issues, National Minority AIDS Council, California Budget Project, and Coalition for Immigrant and Refugee Rights and Services.

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