APPENDIX 2
NCQA PCMH 2011 AND CMS STAGE 1 MEANINGFUL USE REQUIREMENTS

CMS Meaningful Use Requirements*

All Providers Must Meet…

- A core set of 15 requirements
- Five of 10 menu requirements
  - Five must include *one* of the following:
    - The capability to submit electronic data to immunization registries/information systems, ***or***
    - The capability to submit electronic syndromic surveillance data to public health agencies

* https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#BOOKMARK4

PCMH 2011 Standards and Elements *Core Requirements **Menu Requirements		Stage 1 Meaningful Use Requirements (Core and Menu)
Overarching Requirement		
In the PCMH 2011 on-line application a practice provides the name and number of the software the practice uses in the PCMH 2011 application and attests to implementing the required security risk analysis needed and correction of security deficiencies. • To meet the federal Core and Menu Meaningful Use requirements, practices must perform the designated factors (*Core, **Menu) using a certified EHR that has undergone a security risk analysis. • U.S. Department of Health & Human Services, Health Information Privacy Web site link: http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/index.html		CORE REQUIREMENTS 15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
PCMH 1: Enhance Access and Continuity		
1A: Access During Office Hours *MUST PASS*	The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: • Providing same-day appointments • Providing timely clinical advice by telephone during office hours • Providing timely clinical advice by secure electronic messages during office hours • Documenting clinical advice in the patient medical record.	

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PCMH 1: Enhance Access and Continuity		
1B: After-Hours Access	The practice has a written process and defined standards and demonstrates that it monitors performance against the standards for: 1. Providing access to routine and urgent-care appointments outside regular business hours 2. Providing continuity of medical record information for care and advice when office is not open 3. Providing timely clinical advice by telephone when the office is not open 4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open 5. Documenting after hours clinical advice in patient records	
1C: Electronic Access	The practice provides the following information and services to patients and families through a secure electronic system. 1. More than 50 percent of patients who request an electronic copy of their health information (e.g., problem lists, diagnoses, diagnostic test results, medication lists and allergies) receive it within three business days* 2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists and allergies) within four business days of when the information is available to the practice** 3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days* 4. Two-way communication between patients/families and the practice 5. Request for appointments or prescription refills 6. Request for referrals or test results.	CORE REQUIREMENTS 12. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days. *Exclusion:* Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. 13. Provide clinical summaries for patients for each office visit Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. *Exclusion:* Any EP who has no office visits during the EHR reporting period). MENU REQUIREMENT 5. Provide patients with timely electronic access to health information (including lab results, problem list, medication lists and allergies) within 4 business days of information being available to the EP At least 10% of patients are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. *Exclusion:* Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.

PCMH 2011 Standards and Elements *Core Requirements **Menu Requirements		Stage 1 Meaningful Use Requirements (Core and Menu)
PCMH 1: Enhance Access and Continuity		
1D: Continuity	The practice provides continuity of care for patients/families by: 1. Expecting patients/families to select a personal clinician 2. Documenting the patient's/family's choice of clinician 3. Monitoring the percentage of patient visits with selected clinician or team.	
1E: Medical Home Responsibilities	The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following. 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside of the practice 4. The care team provides the patient/family with access to evidence-based care and self-management support	
1F: Culturally and Linguistically Appropriate Services (CLAS)	The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families. 1. Assesses the racial and ethnic diversity of its population 2. Assesses the language needs of its population 3. Provides interpretation or bilingual services to meet the language needs of its population 4. Provides printed materials in the languages of its population	
1G: The Practice Team	The practice provides a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Holding regular team meetings and communication processes 3. Using standing orders for services 4. Training and assigning care teams to coordinate care for individual patients 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills 8. Involving care team staff in the practice's performance evaluation and quality improvement activities	

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PCMH 2: Identify and Manage Patient Populations		
2A: Patient Information	The practice uses an electronic system that records the following as structured (searchable) data for more than 50 percent of the patients. 1. Date of birth* 2. Gender* 3. Race* 4. Ethnicity* 5. Preferred language* 6. Telephone numbers 7. E-mail address 8. Dates of previous clinical visits 9. Legal guardian/health care proxy 10. Primary caregiver 11. Presence of advance directives (NA for pediatric practices) 12. Health insurance information	CORE REQUIREMENT 7. Record all of the following demographics • Preferred language • Gender • Race • Ethnicity • Date of birth More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
2B: Clinical Data	The practice uses an electronic system to record the following as structured (searchable) data. 1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients 2. Allergies, including medication allergies and adverse reactions* for more than 80 percent of patients 3. Blood pressure, with the date of update for more than 50 percent of patients 4. Height for more than 50 percent of patients 5. Weight for more than 50 percent of patients 6. BMI for more than 50 percent of adult patients 7. Length/height, weight, and head circumference (less than 2 years of age) and BMI percentile (2-20 years) for more than 50 percent of pediatric patients, with the capability to plot changes over time 8. Status of tobacco use for patients 13 years and older for more than 50 percent of patients 9. List of prescription medications with date of updates for more than 80 percent of patients	CORE REQUIREMENTS 3. Maintain an up-to date problem list of current and active diagnoses. More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data. 5. Maintain active medication list More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. 6. Maintain active medication allergy list More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. 8. Record and chart changes in the following vital signs • Height • Weight • Blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2-20 years, including BMI. For more than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data.

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PCMH 2: Identify and Manage Patient Populations		
		Exclusion: Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. 9. Record smoking status for patients 13 years old or older More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data *Exclusion:* Any EP who sees no patients 13 years or older
2C: Comprehensive Health Assessment	To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: 1. Documentation of age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Patient and family mental health/substance abuse 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) 9. Depression screening for adults and adolescents using a standardized tool.	
2D: Use Data for Population Management *MUST PASS*	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: 1. At least three different preventive care services** 2. At least three different chronic or acute care services** 3. Patients not recently seen by the practice 4. Specific medications	MENU REQUIREMENT 3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach Generate at least one report listing patients of the EP with a specific condition. 4. Send reminders to patients per patient preference for preventive/ follow-up care More than 20% of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. Exclusion: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR

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PCMH 3: Plan and Manage Care		
3A: Implement Evidence-Based Guidelines	The practice implements evidence-based guidelines through point of care reminders for patients with: 1. The first important condition* 2. The second important condition* 3. The third condition, related to unhealthy behaviors or mental health or substance abuse	CORE REQUIREMENT 11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule. Implement one clinical decision support rule
3B: Identify High-Risk Patients	To identify high-risk or complex patients the practice: 1. Establishes criteria and a systematic process to identify high-risk or complex patients 2. Determines the percentage of high-risk or complex patients in its population.	
3C: Care Management *MUST PASS*	The care team performs the following for at least 75 percent of the patients for the patients identified in Elements A and B: 1. Conducts pre-visit preparations 2. Collaborates with the patient/family to develop an individualized care plan, including treatment goals that are reviewed and updated at each relevant visit 3. Gives the patient/family a written plan of care 4. Assesses and addresses barriers when patient has not met treatment goals 5. Provides patient/family a clinical summary at each relevant visit 6. Identifies patients/families who might benefit from additional care management support 7. Follows up with patients/families who have not kept important appointments	
3D: Medication Management	The practice manages medications in the following ways. 1. Reviews and reconciles medications with patients/families for more than 50 percent of care transitions** 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions 3. Provides information about new prescriptions to more than 80 percent of patients/families 4. Assesses patient/family understanding of medications for more than 50 percent of patients 5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families with the date of updates.	MENU REQUIREMENT 7. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP. *Exclusion:* An EP who was not the recipient of any transitions of care during the EHR reporting period.

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PCMH 3: Plan and Manage Care		
3E: Use Electronic Prescribing	The practice uses an electronic prescription system with the following capabilities. 1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies* 2. Generates at least 75 percent of eligible prescriptions* 3. Integrates with patient medical records 4. Performs patient-specific checks for drug-drug and drug-allergy interactions* 5. Alerts prescriber to generic alternatives 6. Alerts prescriber to formulary status.**	CORE REQUIREMENTS 1. Use CPOE (computerized physician order entry) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication entered using CPOE. Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period). 2. Implement drug-drug and drug-allergy interaction checks The EP has enabled this functionality for the entire EHR reporting period 4. Generate and transmit permissible prescriptions electronically (eRx) More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology *Exclusion:* Any EP who writes fewer than 100 prescriptions during the reporting period. MENU REQUIREMENT 1. Implement drug formulary checks The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. *Exclusion:* Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
PCMH 4: Provide Self-Care Support and Community Resources		
4A: Support Self-Care Process *MUST PASS*	The practice conducts activities to support patients/families in self-management: 1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management 2. Uses an EHR to identify patient-specific education resources and provide to more than 10 percent of patients, if appropriate** 3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families 4. Documents self-management abilities for at least 50 percent of patients/families 5. Provides self-management tools to record self-care results for at least 50 percent of patients/families 6. Counsels at least 50 percent of patients/families to adopt healthy behaviors	MENU REQUIREMENT 6. Use certified EHR to identify patient-specific education resources and provide those resources to the patient if appropriate. More than 10% of all unique patients seen by the EP are provided patient-specific education resources.

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PCMH 4: Provide Self-Care Support and Community Resources		
4B: Provide Referrals to Community Resources	The practice supports patients/families that need access to community resources: 1. Maintains a current resource list on five topics or key community service areas of importance to practice population 2. Tracks referrals provided to patients/families 3. Arranges or provides treatment for mental health and substance abuse disorders 4. Offers opportunities for health education and peer support.	
PCMH 5: Track and Coordinate Care		
5A: Test Tracking and Follow-Up	The practice has a documented process for and demonstrates that it: 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows-up with inpatient facility on newborn hearing and newborn blood-spot screening (NA for adults) 7. Electronically communicates with labs to order tests and retrieve results 8. Electronically communicates with facilities to order and retrieve imaging results 9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in the medical record** 10. Electronically incorporates imaging test results into in the medical record.	MENU REQUIREMENT 2. Incorporate clinical lab test results into EHR as structured data More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. *Exclusion:* An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

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PCMH 5: Track and Coordinate Care		
5B: Referral tracking and Follow-Up *MUST PASS*	The practice coordinates referrals by: 1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information 2. Tracking the status of the referrals, including required timing for receiving a specialist's report 3. Following up to obtain specialist's report 4. Establishing and documenting agreements with specialists in the medical record if co-management is needed 5. Asking patients/families about self-referrals and requesting reports from clinicians 6. Demonstrating capacity for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians* 7. Providing an electronic summary of care record for more than 50 percent of referrals.**	CORE REQUIREMENT 14. Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. MENU REQUIREMENT 8. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. *Exclusion:* An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
5C: Coordinate With Facilities and Care Transitions	On its own or in conjunction with an external organization, the practice systematically: 1. Demonstrates its process for identifying patients with a hospital admission or emergency department visit 2. Demonstrates its process for sharing clinical information with the admitting hospital or emergency department 3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities 4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization 6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA if practice only treats adults) 7. Demonstrates the ability for electronic exchange of key clinical information with facilities* 8. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care.**	CORE REQUIREMENT 14. Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. MENU REQUIREMENT 8. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. *Exclusion:* An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

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PCMH 6: Measure and Improve Performance		
6A: Measure Performance	The practice measures or receives data on the following: 1. At least three preventive care measures 2. At least three chronic or acute care clinical measures 3. At least two utilization measures affecting health care costs 4. Performance data stratified for vulnerable populations (to assess disparities in care).	
6B: Measure Patient/Family Experience	• The practice obtains feedback from patients/families on experiences with the practice and their care. • 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 • The practice uses the Patient-Centered Medical Home version of the CAHPS Clinician & Group survey tool • The practice obtains feedback on experiences of vulnerable patient groups • The practice obtains feedback from patients/families through qualitative means.	
6C: Implement Continuous Quality Improvement *MUST PASS*	The practice uses an ongoing quality improvement process to: 1. Set goals and act to improve on at least three measures from Element A 2. Set goals and act to improve quality on at least one measure from Element B 3. Set goals and address at least one identified disparity in care/service for vulnerable populations 4. Involve patients/families in quality improvement teams or on the practice's advisory council.	
6D: Demonstrate Continuous Quality Improvement	The practice demonstrates ongoing monitoring the effectiveness of its improvement process by: 1. Tracking results over time 2. Assessing the effect of its actions 3. Achieving improved performance on one measure 4. Achieving improved performance on a second measure	

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PCMH 6: Measure and Improve Performance		
6E: Report Performance	The practice shares performance data from Element A and Element B: 1. Within the practice, results by individual clinician 2. Within the practice, results across the practice 3. Outside the practice to patients or the public, results across the practice or by clinician.	
6F: Report Data Externally	The practice electronically reports: 1. Ambulatory clinical quality measures to CMS* 2. Data to immunization registries or systems** 3. Syndromic surveillance data to public health agencies.**	CORE REQUIREMENT 10. Report ambulatory clinical quality measures to CMS Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS. For requirements and electronic specifications related to individual ambulatory clinical quality measures, refer to: http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopofPage MENU REQUIREMENTS 9. Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically.) *Exclusion:* Any EPs who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically. 10. Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive electronically). *Exclusion:* An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.