Patient-Centered Medical Home (PCMH) 2017: Suggested Pathway

The table below provides a suggested pathway for what practices might demonstrate for each check-in. A practice does not have to follow this pathway. This table was developed to provide direction and a to practices for how to approach the concepts and criteria.

To achieve recognition, practices must:

1. Meet all 40 core criteria and
2. Earn 25 credits in elective criteria across 5 of 6 concepts.

Multi-sites: Shared and Site-Specific Evidence

Some evidence can be shared (such as documented processes and demonstration of capability) and may be submitted once for all sites or site groups. Other evidence (such as evidence of implementation, examples, reports, Record Review Workbooks and Quality Improvement Workbooks) must be site-specific. Site -specific data may be combined and submitted once on behalf of all sites or site groups. Some criteria require a combination of shared and site-specific evidence, which is indicated as partially shared in the tables below. For multi-site groups, it is suggested that the group demonstrate their shared criteria during their 1st check-in and then all of their site-specific evidence for all of their sites at the subsequent check-ins.

 = Evidence sharable across practice sites

 ** = Evidence that can be partially shared

	Core	Electives		
		1 Credit	2 Credits	3 Credits
Total Criteria (100 criteria)	**40 criteria**	**39 criteria**	**20 criteria**	**1 criterion**

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)					
Competency A: The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.			**Check-in 1**	**Check-in 2**	**Check-in 3**
TC 01* (Core) 	PCMH Transformation Leads	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	✓		
TC 02 (Core) 	Structure & Staff Responsibilities	Defines practice organizational structure and staff responsibilities/ skills to support key PCMH functions.	✓		

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)					
TC 03* (1 Credit)	External PCMH Collaborations	The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).			✓
TC 04 * (2 Credits)	Patient/Family/Caregiver Involvement in Governance	Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.		✓	
TC 05 (2 Credits)	Certified EHR System	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis and implements security updates as necessary correcting identified security deficiencies.	✓		
Competency B: Communication among staff is organized to ensure that patient care is coordinated, safe and effective.			**Check-in 1**	**Check-in 2**	**Check-in 3**
TC 06 (Core) **	Individual Patient Care Meetings/Communication	Has regular patient care team meetings or a structured communication process focused on individual patient care.	✓		
TC 07 (Core)	Staff Involvement in Quality Improvement	Involves care team staff in the practice's performance evaluation and quality improvement activities.	✓		
TC 08* (2 Credits)	Behavioral Health Care Manager	Has at least one care manager qualified to identify and coordinate behavioral health needs.		✓	
Competency C: The practice communicates and engages patients on expectations and their role in the medical home model of care.			**Check-in 1**	**Check-in 2**	**Check-in 3**
TC 09 (Core)	Medical Home Information	Has a process for informing patients/ families/caregivers about the role of the medical home and provides patients/ families/caregivers with materials that contain the information.	✓		
Core Review: 2 criteria **Core Attestation:** 3 criteria		**1 Credit Review:** 0 criteria **1 Credit Attestation:** 1 criteria	**2 Credit Review:** 2 criteria **2 Credit Attestation:** 1		

TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)
criteria

*New criteria in PCMH 2017.

KNOWING AND MANAGING YOUR PATIENTS (KM)					
Competency A: Practice routinely collects comprehensive data on patients to understand background and health risks of patients. Practice uses information on the population to implement needed interventions, tools and supports for the practice as a whole and for specific individuals.			**Check-in 1**	**Check-in 2**	**Check-in 3**
KM 01 (Core)	Problem Lists	Documents an up-to-date problem list for each patient with current and active diagnoses.	✓		
KM 02 (Core) *F. and G. are new **	Comprehensive Health Assessment	Comprehensive health assessment includes (all items required): A. Medical history of patient and family B. Mental health/substance use history of patient and family C. Family/social/cultural characteristics D. Communication needs. E. Behaviors affecting health F. Social functioning* G. Social Determinants of Health* H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices)	✓		
KM 03 (Core) **	Depression Screening	Conducts depression screenings for adults and adolescents using a standardized tool.	✓		
KM 04* (1 Credit) **	Behavioral Health Screenings	Conducts behavioral health screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety. B. Alcohol use disorder.	✓		

KNOWING AND MANAGING YOUR PATIENTS (KM)					
		C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. ADHD. G. Postpartum depression.			
KM 05* (1 Credit)  **	Oral Health Assessment & Services	Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.	✓		
KM 06 (1 Credit) 	Predominant Conditions & Concerns	Identifies the predominant conditions and health concerns of the patient population.		✓	
KM 07* (2 Credits)	Social Determinants of Health	Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.		✓	
KM 08* (1 Credit) 	Patient Materials	Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.			✓
Competency B: The practice seeks to meet the needs of a diverse patient population by understanding the population's unique characteristics and language needs. The practice uses this information to ensure linguistic and other patient needs are met.			**Check-in 1**	**Check-in 2**	**Check-in 3**
KM 09 (Core)	Diversity	Assesses the diversity (race, ethnicity and one other aspect of diversity) of its population.	✓		
KM 10 (Core)	Language	Assesses the language needs of its population.	✓		
KM 11 (1 Credit) *A. and C.	Population Needs	Identifies and addresses population-level needs based on the diversity of the practice and the community			✓

KNOWING AND MANAGING YOUR PATIENTS (KM)					
are new 		(demonstrate at least 2): A. Target population health management on disparities in care.* B. Address health literacy of the practice. C. Educate practice staff in cultural competence.*			
Competency C: The practice proactively addresses the care needs of the patient population to ensure needs are met.			**Check-in 1**	**Check-in 2**	**Check-in 3**
KM 12 (Core) 	Proactive Reminders	Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least 3 categories): A. Preventive care services. B. Immunizations. C. Chronic or acute care services. D. Patients not recently seen by the practice.	✓		
KM 13* (2 Credits)	Excellence in Performance	Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines. [Specifics yet to be defined but at minimum includes DRP/HSRP recognition by NCQA.]			✓
Competency D: The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation and assessment of barriers.			**Check-in 1**	**Check-in 2**	**Check-in 3**
KM 14 (Core)	Medication Reconciliation	Reviews and reconciles medications for more than 80 percent of patients received from care transitions.		✓	
KM 15 (Core)	Medication Lists	Maintains an up-to-date list of medications for more than 80 percent of patients.		✓	

KNOWING AND MANAGING YOUR PATIENTS (KM)					
KM 16 (1 Credit)	New Prescription Education	Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/ caregivers.		✓	
KM 17 (1 Credit)	Medication Responses & Barriers	Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.		✓	
KM 18* (1 Credit)	Controlled Substance Database Review	Reviews controlled substance database when prescribing relevant medications.			✓
KM 19* (2 Credits)	Prescription Claims Data	Systematically obtains prescription claims data in order to assess and address medication adherence.			✓
Competency E: The practice incorporates evidence-based clinical decision support across a variety of conditions to ensure effective and efficient care is provided to patients.			**Check-in 1**	**Check-in 2**	**Check-in 3**
KM 20 (Core)	Clinical Decision Support	Implements clinical decision support following evidence-based guidelines for care of (must demonstrate at least 4 criteria): A. Mental health condition. B. Substance use disorder. C. A chronic medical condition. D. An acute condition. E. A condition related to unhealthy behaviors. F. Well child or adult care. G. Overuse/appropriateness issues.		✓	
Competency F: The practice identifies/considers and establishes connections to community resources to collaborate and direct patients to needed support.			**Check-in 1**	**Check-in 2**	**Check-in 3**
KM 21* (Core)	Community Resource Needs	Uses information on the population served by the practice to prioritize needed	✓		

KNOWING AND MANAGING YOUR PATIENTS (KM)					
		community resources.			
KM 22 (1 Credit)	Access to Educational Resources	Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.		✓	
KM 23* (1 Credit)	Oral Health Education	Provides oral health education resources to patients.			✓
KM 24 (1 Credit)	Shared Decision-Making Aids	Adopts shared decision-making aids for preference-sensitive conditions.			✓
KM 25* (1 Credit)	School/Intervention Agency Engagement	Engages with schools or intervention agencies in the community.			✓
KM 26 (1 Credit)	Community Resource List	Routinely maintains a current community resource list based on the needs identified in Core KM 21.		✓	
KM 27 (1 Credit)	Community Resource Assessment	Assesses the usefulness of identified community support resources.			✓
KM 28* (2 Credits)	Case Conferences	Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists).		✓	
Core Review: 4 criteria **Core Attestation:** 6 criteria		**1 Credit Review:** 6 criteria **1 Credit Attestation:** 8 criteria	**2 Credit Review:** 4 criteria **2 Credit Attestation:** 0 criteria		

* New criteria in PCMH 2017.

PATIENT-CENTERED ACCESS AND CONTINUITY (AC)					
Competency A: The practice seeks to enhance access by providing appointments and clinical advice based on patients' needs.			**Check-in 1**	**Check-in 2**	**Check-in 3**
AC 01* (Core) **	Access Needs & Preferences	Assesses the access needs and preferences of the patient population.	✓		
AC 02 (Core) **	Same-Day Appointments	Provides same-day appointments for routine and urgent care to meet identified patients' needs.	✓		
AC 03 (Core)	Appointments Outside Business Hours	Provides routine and urgent appointments outside regular business hours to meet identified patient needs.	✓		
AC 04 (Core)	Timely Clinical Advice by Telephone	Provides timely clinical advice by telephone.	✓		
AC 05 (Core) **	Clinical Advice Documentation	Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.	✓		
AC 06 (1 Credit) **	Alternative Appointments	Provides scheduled routine or urgent appointments by telephone or other technology supported mechanisms.		✓	
AC 07 (1 Credit)	Electronic Patient Requests	Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.			✓
AC 08 (1 Credit)	Two-Way Electronic Communication	Has a secure electronic system for two-way communication to provide timely clinical advice.			✓
AC 09* (1 Credit)	Equity of Access	Uses information on the population served by the practice to assess equity of access that considers health disparities.			✓

Patient-Centered Medical Home (PCMH) 2017: New Single Site Suggested Pathway

Competency B: Practices support continuity through empanelment and systematic access to the patient's medical record.			**Check-in 1**	**Check-in 2**	**Check-in 3**
AC 10 (Core)	Personal Clinician Selection	Helps patients/families/caregivers select or change a personal clinician.	✓		
AC 11 (Core)	Patient Visits with Clinician/Team	Sets goals and monitors the percentage of patient visits with selected clinician or team.		✓	
AC 12 (2 Credits)	Continuity of Medical Record Information	Provides continuity of medical record information for care and advice when the office is closed.	✓		
AC 13* (1 Credit) **	Panel Size Review & Management	Reviews and actively manages panel sizes.		✓	
AC 14* (1 Credit) **	External Panel Review & Reconciliation	Reviews and reconciles panel based on health plan or other outside patient assignments.			✓
Core Review: 3 criteria **Core Attestation:** 4 criteria		**1 Credit Review:** 3 criteria **1 Credit Attestation:** 3 criteria	**2 Credit Review:** 0 criteria **2 Credit Attestation:** 1 criteria		

*New criteria in PCMH 2017.

CARE MANAGEMENT AND SUPPORT (CM)					
Competency A: The practice systematically identifies patients that would benefit most from care management.			**Check-in 1**	**Check-in 2**	**Check-in 3**
CM 01 (Core)	Identifying Patients for Care Management	Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least 3 in its criteria): A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/ caregiver	✓		
CM 02 (Core)	Monitoring Patients for Care Management	Monitors the percentage of the total patient population identified through its process and criteria.	✓		
CM 03* (2 Credits)	Comprehensive Risk-Stratification Process	Applies a comprehensive risk-stratification process to entire patient panel in order to identify and direct resources appropriately.		✓	
Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/ caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.			**Check-in 1**	**Check-in 2**	**Check-in 3**
CM 04 (Core)	Person-Centered Care Plans	Establishes a person-centered care plan for patients identified for care management.		✓	
CM 05 (Core)	Written Care Plans	Provides written care plan to the patient/family/caregiver for patients identified for care management.		✓	
CM 06 (1 Credit)	Patient Preferences & Goals	Documents patient preference and functional/lifestyle goals in individual care plans.		✓	

CARE MANAGEMENT AND SUPPORT (CM)					
CM 07 (1 Credit)	Patient Barriers to Goals	Identifies and discusses potential barriers to meeting goals in individual care plans.		✓	
CM 08 (1 Credit)	Self-Management Plans	Includes a self-management plan in individual care plans.		✓	
CM 09* (1 Credit)	Care Plan Integration	Care plan is integrated and accessible across settings of care.			✓
Core Review: 2 criteria **Core Attestation:** 2 criteria		**1 Credit Review:** 1 criterion **1 Credit Attestation:** 3 criteria		**2 Credit Review:** 1 criterion **2 Credit Attestation:** 0 criteria	

*New criteria in PCMH 2017

CARE COORDINATION AND CARE TRANSITIONS (CC)					
Competency A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.			**Check-in 1**	**Check-in 2**	
CC 01 (Core) **	Lab & Imaging Test Management	The practice systematically manages lab and imaging tests by: A. Tracking lab tests until results are available, flagging and following up on overdue results. B. Tracking imaging tests until results are available, flagging and following up on overdue results. C. Flagging abnormal lab results, bringing them to the attention of the clinician. D. Flagging abnormal imaging results, bringing them to the attention of the clinician. E. Notifying patients/families/ caregivers of normal lab and imaging test results. F. Notifying patients/families/ caregivers of abnormal lab and imaging test results.	✓		
CC 02 (1 Credit) **	Newborn Screenings	Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening.	✓		
CC 03* (2 Credits)	Appropriate Use for Labs & Imaging	Uses clinical protocols to determine when imaging and lab tests are necessary.		✓	
Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.			**Shared or Site-Specific?**	**Review or Attestation?**	

CARE COORDINATION AND CARE TRANSITIONS (CC)					
CC 04 (Core) **	Referral Management	The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical question, the required timing and the type of referral B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports	✓		
CC 05* (2 Credits)	Appropriate Referrals	Uses clinical protocols to determine when a referral to a specialist is necessary.		✓	
CC 06* (1 Credit)	Commonly Used Specialists Identification	Identifies the specialists/specialty types most commonly used by the practice.		✓	
CC 07 (2 Credits)	Performance Information for Specialist Referrals	Considers available performance information on consultants/ specialists when making referrals.		✓	
CC 08 (1 Credit)	Specialist Referral Expectations	Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.	✓		
CC 09 (2 Credits)	Behavioral Health Referral Expectations	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.		✓	

CARE COORDINATION AND CARE TRANSITIONS (CC)					
CC 10 (2 Credits) **	Behavioral Health Integration	Integrates behavioral healthcare providers into the care delivery system of the practice site.		✓	
CC 11 (1 Credit) **	Referral Monitoring	Monitors the timeliness and quality of the referral response.	✓		
CC 12 (1 Credit)	Co-Management Arrangements	Documents co-management arrangements in the patient's medical record.		✓	
CC 13* (2 Credits) **	Treatment Options & Costs	Engages with patients regarding cost implications of treatment options.			✓
Competency C: The practice connects with other health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.			**Check-in 1**	**Check-in 2**	**Check-in 3**
CC 14 (Core) **	Identifying Unplanned Hospital & ED Visits	Systematically identifies patients with unplanned hospital admissions and emergency department visits.	✓		
CC 15 (Core) **	Sharing Clinical Information	Shares clinical information with admitting hospitals and emergency departments.		✓	
CC 16 (Core) **	Post-Hospital/ED Visit Follow-Up	Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	✓		
CC 17* (1 Credit) **	Acute Care After Hours Coordination	Systematic ability to coordinate with acute care settings after hours through access to current patient information.			✓
CC 18 (1 Credit) **	Information Exchange during	Exchanges patient information with the hospital during a patient's			✓

CARE COORDINATION AND CARE TRANSITIONS (CC)					
	Hospitalization	hospitalization.			
CC 19 (1 Credit) **	Patient Discharge Summaries	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities.		✓	
CC 20 (1 Credit)	Care Plan Collaboration for Practice Transitions	Collaborates with the patient/ family/caregiver to develop/ implement a written care plan for complex patients transferring into/out of the practice (e.g., from pediatric care to adult care).		✓	
CC 21 (Maximum 3 Credits)	External Electronic Exchange of Information	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit) B. Immunization registries or immunization information systems. (1 Credit) C. Summary of care record to another provider or care facility for care transitions. (1 Credit)			✓
Core Review: 2 criteria	**1 Credit Review:** 2 criteria	**2 Credit Review:** 5 criteria	**3 Credit Attestation**: 1 criterion		
Core Attestation: 3 criteria	**1 Credit Attestation:** 7 criteria	**2 Credit Attestation:** 1 criterion			

*New criteria in PCMH 2017

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)					
Competency A: The practice measures to understand current performance and to identify opportunities for improvement.			**Check-in 1**	**Check-in 2**	**Check-in 3**
QI 01 (Core) **D. is New*	Clinical Quality Measures	Monitors at least five clinical quality measures across the four categories (must monitor at least 1 measure of each type): A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures.*	✓		
QI 02 (Core)	Resource Stewardship Measures	Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): A. Measures related to care coordination. B. Measures affecting health care costs.	✓		
QI 03 (Core) **	Appointment Availability Assessment	Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	✓		
QI 04 (Core)	Patient Experience Feedback	Monitors patient experience through: A. Quantitative data: Conducts a survey (using any instrument) to evaluate patient/family/ caregiver experiences across at least three dimensions, such as: • Access. • Communication. • Coordination. • Whole person care,	✓		

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)					
		self-management support and comprehensiveness. B. Qualitative data: Obtains feedback from patients/ families/caregivers through qualitative means			
QI 05 (1 Credit)	Health Disparities Assessment	Assesses health disparities using performance data stratified for vulnerable populations. (must choose one from each section): A. Clinical quality B. Patient experience		✓	
QI 06 (1 Credit)	Validated Patient Experience Survey Use	The practice uses a standardized, validated patient experience survey tool with benchmarking data available.			✓
QI 07 (2 Credits)	Vulnerable Patient Feedback	The practice obtains feedback on experiences of vulnerable patient groups.		✓	
Competency B: The practice evaluates its performance against goals or benchmarks and uses the results to prioritize and implement improvement strategies.			**Check-in 1**	**Check-in 2**	**Check-in 3**
QI 08 (Core) **D. is New*	Goals & Actions to Improve Clinical Quality Measures	Sets goals and acts to improve upon at least three measures across at least three of the four categories: A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures.*		✓	

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)					
QI 09 (Core)	Goals & Actions to Improve Resource Stewardship Measures	Sets goals and acts to improve upon at least one measure of resource stewardship: A. Measures related to care coordination. B. Measures affecting health care costs.		✓	
QI 10 (Core)	Goals & Actions to Improve Appointment Availability	Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.		✓	
QI 11 (Core)	Goals & Actions to Improve Patient Experience	Sets goals and acts to improve on at least 1 patient experience measure.		✓	
QI 12 (2 Credits)	Improved Performance	Achieves improved performance on at least 2 performance measures.			✓
QI 13 (1 Credit)	Goals & Actions to Improve Disparities in Care/Service	Sets goals and acts to improve disparities in care or services on at least 1 measure.		✓	
QI 14 (2 Credits)	Improved Performance for Disparities in Care/ Service	Achieves improved performance on at least 1 measure of disparities in care or service.			✓
Competency C: The practice is accountable for performance. The practice shares performance data with the practice, patients and/or publicly for the measures and patient populations identified in the previous section.			**Check-in 1**	**Check-in 2**	**Check-in 3**
QI 15 (Core) **	Reporting Performance within the Practice	Reports practice-level or individual clinician performance results within the practice for measures reported by the practice.	✓		
QI 16 (1 Credit) **	Reporting Performance Publicly or with Patients	Reports practice-level or individual clinician performance results publicly or with patients for measures reported by		✓	

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT (QI)					
		the practice.			
QI 17 (2 Credits)	Patient/Family/Caregiver Involvement in Quality Improvement	Involves patient/family/caregiver in quality improvement activities.		✓	
QI 18 (2 Credits)	Reporting Performance Measures to Medicare/Medicaid	Reports clinical quality measures to Medicare or Medicaid agency.			✓
QI 19* (Maximum 2 credits)	Value-Based Contract Agreements • Up-Side Risk Contract • Two-Sided Risk Contract	Is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side risk contract (1 credit) B. Practice engages in two-sided risk contract (2 credits)			✓
Core Review: 9 criteria **Core Attestation:** 0 criteria		**1 Credit Review:** 0 criteria **1 Credit Attestation:** 4 criteria	**2 Credit Review:** 2 criteria **2 Credit Attestation:** 4 criteria		

*New criteria in PCMH 2017.