Patient-Centered Medical Home Toolkit for Health Centers

Guidance for HRSA Health Centers in Implementing and Sustaining the PCMH Model

NCQA
Measuring quality. Improving health care.

Contents

SECTION 1

Executive Summary

The nation's health centers provide access to primary care services and a primary care medical home to more than 28 million patients. These services, as well as integrated dental and behavioral health services, are coordinated in approximately 1,400 health centers and 12,000 delivery sites.[1]

The Health Resources and Services Administration (HRSA) continues to invest in health centers to ensure that patients in limited resourced communities receive quality, patient-centered, affordable health care. In doing so, HRSA provides standards and guidelines for not only the development of health centers, but also for their oversight.

In seeking the highest-quality health care for limited resourced communities, HRSA also supports centers that attain and maintain National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Recognition by providing quality improvement awards and technical assistance. HRSA's support demonstrates its commitment to health care access; team-based, coordinated care; and quality improvement. Gaining PCMH Recognition will help health centers develop these aspects of care, while increasing patient and staff satisfaction and reducing costs.

HRSA's Health Center Program Compliance Manual provides the statutory and regulatory requirements for which grantees must demonstrate compliance. Operational Site Visits (OSV) based on the manual give HRSA the opportunity to review health center compliance. HRSA uses the Uniform Data System (UDS) to assess the operational, financial and clinical quality performance of the nation's health centers and other HRSA grantees.[2]

1. Bphc.hrsa.gov. (2019). [online] Available at: https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf [Accessed 1 Dec. 2019].
2. Bphcdata.net. (2019). Uniform Data System: Reporting Instructions for the 2019 Health Center Data. [online] Available at: http://www.bphcdata.net/docs/uds_rep_instr.pdf [Accessed 1 Dec. 2019].

In maintaining the rigorous HRSA requirements, centers demonstrate that their mission, structure and processes align with NCQA's PCMH concepts. In preparation for HRSA UDS submissions or OSVs, centers capture both data and processes relevant to PCMH and as a result, have the foundation to define, assess and enhance the medical home model of care. Health centers may already have adopted many of the processes of a PCMH. NCQA will help your sites become more transparent and accountable by facilitating consistent tracking and reporting.

This toolkit provides an overview of the patient-centered medical home model and guides centers through the NCQA PCMH Recognition process. The toolkit:

Explains the benefits of NCQA PCMH Recognition.

Illustrates how the HRSA health center program fosters an environment of patient-centered care and how the HRSA requirements align with NCQA PCMH Recognition.

Explains how the health center organizational structure, as outlined in the Health Center Program Compliance Manual, supports transformation to a medical home.

Demonstrates alignment of NCQA PCMH concepts, competencies and criteria with HRSA UDS, the Medicaid program and social determinants of health (SDOH).

Outlines the steps your health center will take to successfully gain and maintain PCMH Recognition.

Provides an overview of resources to support transformation and maintenance of PCMH Recognition.

SECTION 2

Understanding PCMH

The American Academy of Pediatrics introduced the medical home concept in 1967 as a model of care using evidence-based guidelines and best practices. It puts patients at the forefront of care and tasks the health center with the responsibility for providing or arranging for all the care the patient may need, keeping in mind the medical, behavioral and life challenges a patient may be facing. PCMHs build better relationships between people and their clinical care teams.

As payers look to reward value, and as patients receive care in an increasing number of settings, it is imperative that all members of the care team share information and collaborate with each other—and with patients—to optimize outcomes. Research shows:

- Fragmented care results in poorer care. Greater rates of fragmentation are associated with increased costs, lower quality and higher rates of preventable hospitalizations.[1]
- Integrated care produces better outcomes. Communicating information for shared patient populations results in better care.[2]
- Payers are increasingly supporting PCMH. Because the PCMH model can help patients avoid costly complications, public and commercial payers are increasingly turning to the PCMH model of care.[3]
- PCMH provides a path toward success with value-based contracts. Due to its commitment to patient-centered care and increased access to all populations, health centers that operate as a PCMH have implemented processes that align with value based contracting standards.

1. Frandsen, B.R., K.E. Joynt, J.B. Rebitzer, and A.K. Jha. 2015. "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients." American Journal of Managed care 21(5), 355–62.
2. A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy. 2008. "Organizing the U.S. Health Care Delivery System for High Performance." The Commonwealth Fund, August 2008.
3. Edwards, S.T., A. Bitton, J. Hong, and B.E. Landon. 2014. "Patient-Centered Medical Home Initiatives Expanded in 2009–13: Providers, Patients, and Payment Incentives Increased." Health Affairs.. http://content.healthaffairs.org/content/33/10/1823.full

> "PCMH Recognition has pulled everyone on the team together.
>
> **Mainline Health Systems**

Benefits of PCMH

NCQA's PCMH Recognition is the right thing to do because it helps health centers provide the highest quality of care for patients.

With the patient at the forefront of care, Recognized health centers develop streamlined workflows and adopt a team-based approach that leads to improved quality of care, improved efficiency of the health center, increased patient and staff satisfaction and reduced costs. Research confirms that PCMHs:

> "It will only make you better.
>
> **Mainline Health Systems**

- **Improve quality.** They provide patients with the treatment they need, when they need it.
- **Reduce costs.** They prevent expensive and avoidable hospitalizations, emergency room visits and complications—especially for patients with complex chronic conditions.
- **Improve the patient experience.** They provide the personalized, comprehensive coordinated care that patients want.
- **Improve staff satisfaction.** Their systems and structures help staff work more efficiently.

For health centers with multiple sites, gaining PCMH Recognition for all sites helps create a consistent and streamlined model of care. Additionally, from 2013-2019, HRSA provided a PCMH Quality Improvement award for eligible health centers; a base amount for having one site PCMH recognized and a bonus for every additional site that is PCMH recognized.

NCQA's Recognition Program

In 2008, NCQA released its PCMH Recognition program, the first evaluation program in the country based on the PCMH model. As the organization with the most experience in PCMH Recognition, and having the broadest eligibility requirements, NCQA's Recognition program is preferred by the majority of health centers that have achieved Recognition.

NCQA provides the necessary resources and assistance to help health centers successfully gain and maintain PCMH Recognition.

What Is in the NCQA PCMH Recognition Program?

Today, NCQA's PCMH Recognition program has evolved to feature a set of six concepts that make up a medical home. Underlying these concepts are criteria (activities for which a health center must demonstrate adequate performance to obtain NCQA PCMH Recognition) and competencies, which categorize the criteria (but do not offer credit).

The PCMH **standards and guidelines document** contains these PCMH Recognition program requirements and information your health center must demonstrate to NCQA. These concepts are also explained in detail in section two of this toolkit.

Annual Reporting Guidelines and Quality Improvement

As part of an Annual Reporting process, each year your health center will check in with NCQA to demonstrate that its ongoing activities are consistent with the PCMH model of care. You will attest to some policies and procedures and submit data to NCQA. Annual Reporting is a live process that will sustain your health center's Recognition and will encourage constant improvement in your health center.

You will strengthen your transformation, and as a result, strengthen patient care.

WHAT TO EXPECT

Although reporting annually, rather than the previous requirement of every three years, may seem more daunting, the Annual Reporting requirements are designed to efficiently demonstrate that health centers have maintained their medical home model. Health centers say this is very manageable; many of the metrics required are already tracked by your health center for other aspects of quality reporting required by HRSA. Additionally, Annual Reporting requirements are flexible to meet your health center's unique needs. Here is what you will need to do:

- Submit your Notice of Intent (NOI) for Annual Reporting to HRSA at the very least 3 months, ideally 6 months, before your Recognition anniversary date (your anniversary date is one year from your Recognition date).
- Complete your Annual Reporting 30 days before your Recognition anniversary date.
- Attest that you are performing activities that make up NCQA PCMH requirements.
- Demonstrate that you are embracing measurement and quality improvement.
    - In some cases, this means submitting evidence via documentation.
    - In some cases, this means providing measurement data.

HOW TO PREPARE

Know what is required.

Download the Annual Reporting requirements, which are updated each calendar year. Look at what's expected after Recognition. Keep up to date on changes by visiting **ncqa.org/annualreporting**.

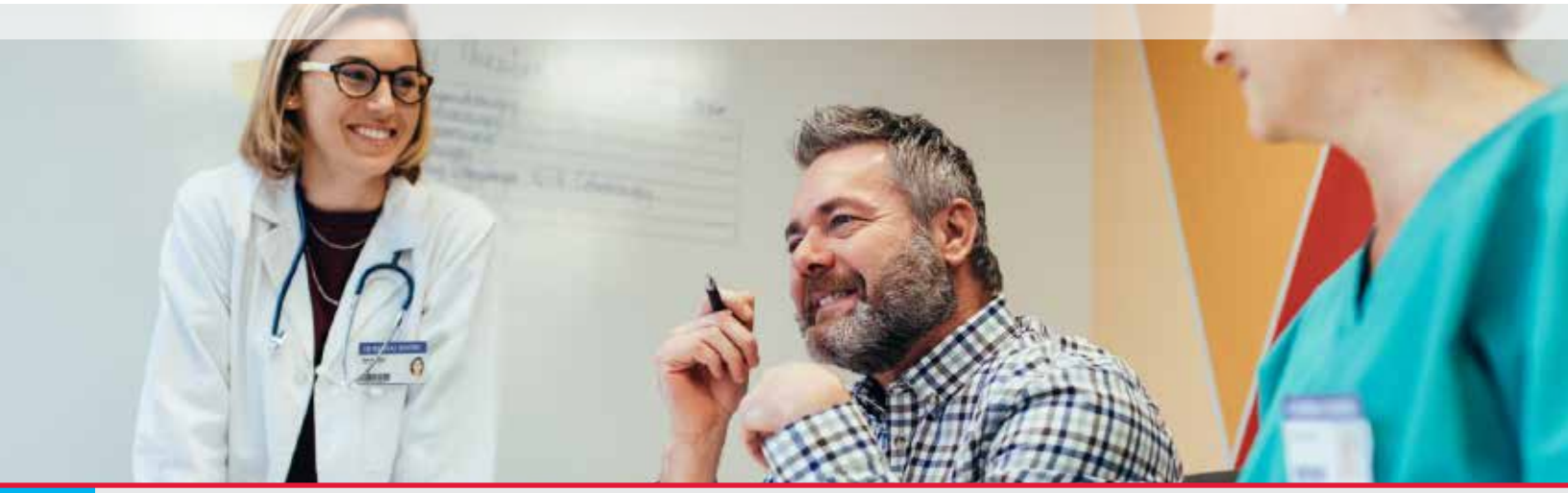
Embrace PCMH and quality improvement.

After you earn Recognition, continue to embrace the PCMH model and activities. Look more closely at quality improvement and performance measurement—it will help when you submit for Annual Reporting next year.

> "Recognition has helped both patient and staff satisfaction, shaped our team-based culture and made the center more patient-centered.
>
> **Salud Para La Gente**

Submit in stages.

You don't have to wait until the month before your anniversary to submit. You can upload and enter—or submit— Annual Reporting requirements at any time during the year, even before your NOI is approved by HRSA. And if you can build submission into existing processes, it becomes part of your quality improvement activities satisfying requirements not just for PCMH Recognition, but also for HRSA and other programs. For example, if you already pull quarterly or monthly reports, make submitting relevant information from those reports in Q-PASS part of the process.



SECTION 3

NCQA PCMH and HRSA Alignment

NCQA's PCMH Recognition program is the most widely adopted PCMH evaluation program in the country.

2,500

Over 2,500 health center sites supported by HRSA are recognized by NCQA, comprising about 18% of all NCQA PCMH sites.

10,000

On average, each site has approximately 4 HRSA clinicians, totaling **over 10,000 clinicians** that work at HRSA sites Recognized by NCQA.

95

More than 95 organizations support NCQA Recognition through providing financial incentives, transformation support, care management, learning collaboratives or Maintenance of Certification (MOC) credit.

HRSA believes that the PCMH model is integral to ensuring their grantee health centers are providing the highest quality healthcare to their varied patient populations. The agency further believes that the PCMH model is the best foundation for ensuring grantees can compete and thrive in the value-based payment environments that are becoming the norm. HRSA has encouraged all its eligible grantees to become Recognized as medical homes.

Your health center may already have adopted many of the processes of a PCMH as a result of complying with HRSA statutory and regulatory requirements. This section will demonstrate how NCQA PCMH concepts, competencies and criteria are aligned with HRSA UDS. Understanding the alignment will help your health center more clearly identify aspects of care that require a closer look during transformation to become NCQA PCMH Recognized.

NCQA PCMH and Center Requirements

NCQA's PCMH program is designed to Recognize health centers that provide compassionate, coordinated care that is accessible, culturally appropriate, linguistically appropriate and patient/family centered. In a true PCMH, team-based, comprehensive health care is provided for preventive, chronic and end-of-life care. PCMH health centers also have systems to obtain and review patient- and population-level data to improve the quality of care they provide.

Similarly, the Health Center Program Compliance Manual requires centers to adhere to the following tasks, which are also building blocks of NCQA's PCMH Recognition program:

- Complete a needs assessment of their patient populations to identify needed updates or changes to the scope of services offered.
- Provide comprehensive, required services ranging from preventive screenings to care coordination and outreach.
- Provide access for limited English proficiency patients, as well as culturally appropriate care.
- Review and analyze clinical staff numbers and ratios to ensure patient access.
- Ensure that office locations and health center hours of operation are based on patient needs.
- Track and coordinate care of hospitalized patients.
- Provide patients with accessible and affordable care, with options for a sliding fee discount program.
- Demonstrate a robust quality improvement and quality assurance program that includes clinical measures and the patient voice (through assessment of patient satisfaction and complaints).
- Ensure continuous quality improvement through specific clinical quality/performance measure results.

Health centers transforming to a PCMH review NCQA's concepts, competencies and criteria and submit evidence (documented processes, reports) to demonstrate compliance with requirements. Although developing, revising and collecting documents can be an involved process, health center leaders and staff are well-equipped for these tasks because document collection is also required to prepare for the OSV and the annual UDS, as are center clinical quality and patient demographic and patient characteristics data. These data elements are fundamental to several NCQA PCMH concepts as well, and centers have the systems and processes in place to adequately report and display this data.

Understanding the similarities in requirements and expectations of centers and medical homes and meeting requirements of the HRSA center program (some are referenced above) fosters an environment for health centers to excel in achieving and sustaining NCQA PCMH Recognition.

In reviewing this toolkit, is important to understand that:

- UDS data represents the financial, clinical and operational status of the entire *center/organization.*
- Centers with *one health center site* may use UDS data (as applicable) for PCMH credit.
- Centers with multiple sites ("multi-site") *may not* submit organizational (aggregate) UDS data for some PCMH criteria.
    - Data is site-specific: Each health center site is required to submit data specific to that site.
    - If the requested evidence is identified as "shared," aggregate UDS data *may be used* for multi-site centers.

TABLE 1: SUBMITTING UDS DATA FOR PCMH CREDIT

	UDS (Aggregate) Data Accepted?	Site-Specific Data Accepted?
Single-site evidence	Yes	N/A
Multi-site evidence	No, unless criteria specify "shared"	Yes

NCQA Concepts and Center Alignment

Team-Based Care and Health Center Organization (TC)

The health center provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work at the top of their license to provide patient-centered care as part of the medical home.

Team-based care is a cornerstone of the PCMH concept. Multiple staff members contribute to patient access to care and the quality of care patients receive. Health centers need to organize the structure of their teams, define the roles and responsibilities of each team member and commit to communication among team members. Teams can strengthen patient engagement by making patients partners in their care.

HRSA COMPLIANCE MANUAL ALIGNMENT

Clinical Staffing requires centers to make staff available to provide required services and to verify the credentials of employed and contractual staff. Team members work at the top of their license under defined roles and responsibilities.

Coverage for Medical Emergencies During and After Hours requires centers to provide information to patients about communicating with the center: whom to contact during an emergency and during and after business hours. This aligns with a core competency of *Team-Based Care and Patient Centered Access and Continuity (AC)*: Inform patients about the role of the medical home and give them instructions on contacting the health center after business hours.

The Quality Improvement/Assurance requirement provides guidance on a quality program with a staff member providing oversight and additional staff members supporting the program.

UDS ALIGNMENT

HRSA expects that health centers have diverse categories of staff to support the health care of the nation's most vulnerable patient population. The UDS requires health centers to report on the types of staff at each health center. In addition to the physician, nurse practitioner, physician assistant and dental clinicians, other members of a health care team are represented in the UDS reporting template: behavioral health professionals, case managers, outreach workers, interpreters, transportation staff and community health workers/promotoras all contribute to team-based care.

Knowing and Managing Your Patients (KM)

The health center captures and analyzes information about the patients and community it serves and uses the information to deliver evidenced-based care that supports population needs and provision of culturally and linguistically appropriate services.

This NCQA concept speaks to the fundamental goal of health centers: Provide access to primary health care services to vulnerable and limited resourced community populations by understanding patient and population needs.

HRSA COMPLIANCE MANUAL ALIGNMENT

Needs Assessment identifies SDOH factors that are assets or barriers to health care access and utilization, and to positive health outcomes. This assessment also provides specific incidence and prevalence data on chronic conditions and health disparities in the community.

Centers can use the results of a Needs Assessment to make strategic decisions on services to offer and can prioritize services to meet the needs of patient populations.

UDS ALIGNMENT

UDS reporting requires health centers to identify and quantify their patient populations based on:

- Patient ZIP code information.
- Patient demographics; for example:
    - Race.
    - Ethnicity.
    - Preferred language.
    - Sexual orientation.
    - Gender identity.
- Patient characteristics; for example:
    - Income.
    - Primary medical insurance.
    - Special populations (e.g., migratory seasonal agriculture workers; veterans; persons experiencing homelessness).

Knowing details about the patient population served directly aligns with the KM concept in general and with patient diversity (KM 09) specifically.

Centers can use UDS data reported in "Selected Diagnoses" (UDS Table 6A) for mental health and substance use disorder to identify populations that require behavioral health screenings or oral health referrals. Data in this table also helps identify the most predominant conditions in patient populations, aiding the health center in improving care through strategic use of practice guidelines, care management services and outreach efforts.

Patient-Centered Access and Continuity (AC)

The PCMH model expects continuity of care. Patients, families and caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The health centers consider the needs and preferences of the patient population when establishing standards for access.

A PCMH uses the patient voice to identify the types of appointments needed and how access to care can be improved.

HRSA COMPLIANCE MANUAL ALIGNMENT

Needs Assessment requires the center to gather information about access preferences from patient and other stakeholder interviews and from service area demographic data.

Accessible Locations and Hours of Operation requires the center to assess its locations and hours to ensure they meet patient expectations for access.

Coverage for Medical Emergencies During and After Hours requires centers to have a process in place for addressing patient needs in a timely manner and ensure that documentation is available in the patient's medical record.

UDS ALIGNMENT

Utilization by Staff Category and by Service Category (UDS Table 5) and Visits by Specific Diagnosis (UDS Table 6A) reports support the NCQA AC concept. They indicate the health needs and urgencies of a patient population. Understanding this helps inform an organization's strategic access plan.

Care Management and Support (CM)

The health center identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

In a PCMH, patients are identified for care management based on criteria identified by the center.

Recommended criteria include patients with:

- Behavioral health diagnoses.
- Poorly controlled conditions.
- Complex medical conditions.
- SDOH.
- Care management referrals from external partners (payers), staff or family members.

After patients are selected for care management, health centers monitor the percentage enrolled in active care management programs and ensure that patients have person-centered care plans that address the specific treatment goals identified by their clinician.

HRSA COMPLIANCE MANUAL ALIGNMENT

Continuity of Care and Hospital Admitting requires centers to identify and track hospitalized patients and ensure appropriate follow-up. These patients are eligible for care management due to their likelihood of chronic or poorly controlled disease and the high cost of their care.

UDS ALIGNMENT

UDS reporting identifies patient characteristics (UDS Table 4) that include, but are not limited to, patients who are agricultural workers or veterans. Housing status, income status and insurance status are also reported in center UDS reports. UDS also reports the number of patients seen for mental health or substance use disorder services. Having this data (which identifies SDOH that may create barriers to positive health outcomes) is a fundamental step toward identifying patients who could benefit from care management services.

UDS data can help centers identify patients who qualify for care management services (CM 01); however, PCMH has additional care management requirements, including requiring health centers to have the ability to risk stratify patients, to develop person-centered care plans, to create functional goals and to identify barriers to meeting goals.

Care Coordination and Care Transitions (CC)

The health center systematically tracks tests, referrals and care transitions to achieve high-quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

PCMH health centers have processes for tracking, following up on and communicating diagnostic testing (radiology and laboratory tests) results and referrals. Health centers must also have processes for receiving notification of patients who have ED visits and hospitalizations, sharing information with other providers and providing seamless transitions for patients discharged home or to external facilities.

HRSA COMPLIANCE MANUAL ALIGNMENT

Required and Additional Services requires the center to have policies for tracking and managing referrals to specialists with whom it has an agreement to provide services. Evidence of these agreements aligns with CC 08 and CC 09: Works with nonbehavioral (CC 08) and behavioral (CC 09) health care specialists to whom the health center frequently refers to set expectations for information sharing and patient care.

Federal Torts Claims Act (FTCA) deeming applications often request evidence of diagnostic testing and referral management policies to evaluate the health center's ability to mitigate and manage risk related to delayed diagnosis and follow-up.

Continuity of Care and Hospital Admitting requires procedures to identify patients who are hospitalized as well as to identify follow-up actions needed to be conducted by center staff with patients that are discharged from inpatient admissions or ED visits.

Performance Management and Quality Improvement (QI)

The health center establishes a culture of data-driven performance improvement on clinical quality, efficiency, and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

PCMH health centers collect, analyze, display and communicate relevant data in an effort to improve clinical performance, operational performance, resource stewardship/health care costs and the patient experience.

HRSA COMPLIANCE MANUAL ALIGNMENT

Quality Improvement/Assurance requires centers to have processes and procedures in place to identify designated staff who supervise quality programs; to identify and apply evidence-based guidelines; to assess patient satisfaction; and to address patient grievances. There is also a mandate for quarterly assessment of select quality measures and for reporting progress to the center board.

UDS ALIGNMENT

The UDS Quality reporting tables provide quality, operational and financial measures from a variety of categories that also correlate with the categories required by NCQA (Table 2).

TABLE 2: NCQA AND UDS QUALITY ALIGNMENT

NCQA Clinical Quality Measure	UDS 2019 Measure examples
Immunization	Childhood immunizations
Other preventive (not including immunizations)	Tobacco use: Screening and cessation intervention
Chronic or acute care clinical	Diabetes: Hemoglobin A1c poor control
Behavioral health	Screening for depression and follow-up plan
Measure related to care coordination	HIV + Linkage to care
Measure affecting health care costs	Pharmaceuticals: Report costs for the vaccines and other stock drugs used by the health center

With systems in place to obtain annual UDS data, a center can use the existing data infrastructure to review data and develop quality improvement initiatives.

NCQA PCMH Core Criteria Alignment With HRSA Center Requirements

TABLE 3: NCQA PCMH CORE CRITERIA ALIGNMENT WITH HRSA CENTER REQUIREMENTS

NCQA Concept and Select Core Criteria	Align With HRSA Compliance Manual	Align With UDS	Health Center Assets
TC 02: Structure and Staff Responsibilities	Clinical Staffing	Table 5: Staffing and Utilization	Centers use diverse staff for clinical support of patient operations and quality initiatives. Staff examples include case managers, outreach workers, community health workers/promotoras de salud, registered nurses, physicians and nurse practitioners.
TC 07: Staff Involved in Quality Improvement	Quality Improvement/Quality Assurance		
TC 09: Medical Home Information	Coverage for Medical Emergencies		
KM 02: Comprehensive Health Assessment		Table 3B: Demographic Characteristics Table 4: Patient Characteristics Table 6A: Selected Diagnoses	Centers have systems and processes to report on social/cultural characteristics, SDOH and behaviors affecting health. Centers have long-standing requirements to report on population characteristics, which helps them understand and manage their population. A key HRSA expectation is to have a Needs Assessment to assist in prioritizing resources the center needs to manage its patient population and provide appropriate health care access to the community.
KM 09: Diversity	Needs Assessment	Zip Code Characteristics Table 3A: Age and Sex Assigned at Birth Table 3B: Demographic Characteristics Table 4: Patient Characteristics Table 6A: Selected Diagnoses	
KM 21: Community Resource Needs	Needs Assessment	Zip Code Characteristics Table 3A: Age and Sex Assigned at Birth Table 3B: Demographic Characteristics Table 4: Patient Characteristics Table 6A: Selected Diagnoses	
AC 01: Access Needs and Preferences	Needs Assessment	Table 5: Staffing and Utilization Table 6A: Selected Diagnoses	The primary objectives of HRSA centers is to provide health care access; as a result, several HRSA standards require that health centers have procedures to obtain access data and to act on the data received. The collection of access data is standard for centers and can be used to meet NCQA PCMH access and continuity standards.
AC 03: Appointments Outside of Business hours	Accessible Locations and Hours of Operation Coverage for Medical Emergencies During and After Hours		
AC 04: Timely Clinical Advice by Telephone	Coverage for Medical Emergencies During and After Hours		
AC 05: Clinical Advice Documentation	Coverage for Medical Emergencies During and After Hours		

NCQA PCMH Core Criteria Alignment With HRSA Center Requirements

TABLE 3: NCQA PCMH CORE CRITERIA ALIGNMENT WITH HRSA CENTER REQUIREMENTS

NCQA Concept and Select Core Criteria	Align With HRSA Compliance Manual	Align With UDS	Health Center Assets
CM 01: Identifying Patients for Care Management	Continuity of Care and Hospital Admitting	Table 4: Patient Characteristics Table 6A: Selected Diagnoses	Centers have systems to identify patients with behavioral health conditions, high cost/ high utilization, poorly controlled/ complex conditions or SDOH in order to enroll a subset of these patients into a care management program.
CM 02: Monitoring Patients for Care Management	Continuity of Care and Hospital Admitting		
CC 04: Referral Management	Required and Additional Services Continuity of Care and Hospital Admitting		Centers are required to have agreements in place to carry out required and/or additional services. These agreements must contain details regarding communication expectations between the health center and external specialist/ consultant.
QI 01: Clinical Quality Measures	Quality Improvement/Quality Assurance	Table 6B: Quality of Care	Centers have the capability to report on the clinical quality and resource stewardship measures, as these are also required in annual HRSA
QI 08: Goals and actions to Improve Clinical Quality Measures		Table 7: Health Outcome Disparities	
QI 09: Goals and Actions to Improve Resource Stewardship Measures		Table 8A: Financial Costs	UDS reporting. Data is not only available for UDS but also for health centers to conduct QI processes on measures by setting goals and improving performance.
QI 15: Reporting Performance Within the health center			HRSA also requires a robust quality improvement and quality assurance program with requirements for sharing performance with the health center's governance team and key management staff. Meeting these compliance items allows for centers to also share performance measure progress to PCMH teams.

SECTION 4

NCQA PCMH and Medicaid Alignment

State Medicaid programs cover the required services delivered by centers. Payments for health services are primarily based on the prospective payment system per encounter. Many states have implemented alternative payment models that have the potential to enhance payment to health centers.[1]

Centers reported in 2018 that almost half (48%) of all patients seen had Medicaid as a principal third-party payer (UDS, Table 4).[2] Medicaid requirements are designed to monitor and improve patient access, utilization, health care costs, clinical quality outcomes and the patient experience—domains found in key NCQA PCMH competencies as well. As such, identifying the alignment between Medicaid and NCQA requirements can help your health center achieve success in both programs, improving patient care.

Access

Medicaid programs collect and review data on patient access to preventive care. Some access measures examine adult preventive visits, well child visits and adolescent well visits. *Patient Centered Access and Continuity (AC)* is a key concept in NCQA PCMH Recognition. It requires centers to monitor visit types and provide same-day access for both preventive and acute care.

The concept *Performance Measurement and Quality Improvement (QI)* requires health centers to monitor preventive measures and patient access to specific appointment types.

Utilization, Care Management and Care Transitions

Medicaid programs have robust data systems to monitor patient utilization of emergency departments and hospital admissions in addition to pharmacy utilization. State Medicaid programs—or Managed Care Organizations (MCO)—also review patient access to (primary and preventive) care in a medical home.

When centers have relationships with the Medicaid program and/or Medicaid MCOs, patient utilization data can assist in the development or augmentation of a care management program. Through care management, centers can engage patients to work with their health care team to plan, manage and coordinate their care (*Care Management and Support [CM]; Care Coordination and Care Transitions [CC]).* If centers need resources to conduct care management, MCOs often have the staff (e.g., patient navigators, case managers) and health promotion and disease management resources to care for complex patient populations.

1. https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf
2. https://bphc.hrsa.gov/uds/datacenter.aspx?q=t4&year=2018&state=

Health Care Costs

Medicaid agencies and Medicaid MCOs have systems in place to monitor and control health care costs, including utilization of EDs, hospitals and primary care facilities. QI 09 (Goals and Actions to Improve Resource Stewardship Measures), in the *Performance Measurement and Quality Improvement (QI)* concept, looks at the centers' review of conserving resources and items affecting health care costs.

Centers can collaborate with their Medicaid partners to identify processes for reducing patient utilization of tertiary care facilities for nonemergency, nonurgent needs.

Clinical Quality Outcomes

State Medicaid and Medicaid MCOs have numerous clinical quality measures that often align with HRSA/UDS measures or are adopted in center quality plans. Many also have Value Based Payment models that provide incentives for meeting or exceeding quality measures. The Health Center Program Compliance Manual requires a quality improvement and quality assurance program. As a result, centers have performance improvement systems in place to achieve Medicaid improvement goals; this contributes to their success with QI competencies and criteria. PCMH QI 18 (Reporting Performance Measures to Medicare/Medicaid) and QI 19 (Value Based Contract Agreements) criteria encourage centers to demonstrate a commitment to quality of care outcomes rather than to a particular number of services offered/provided.

Patient Experience

Many Medicaid programs use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[3]) questionnaire to assess patient experience with health plans and medical providers.

Centers have an opportunity to work with state Medicaid programs and/or MCOs to review aggregate CAHPS results in an effort to identify and improve performance at the-center level.

Medicaid Data

As illustrated, access to Medicaid and Medicaid MCO data gives centers additional information about their patient population; data contributes to successful initiatives for patient access, patient engagement and quality improvement. An additional benefit is that data can be used as NCQA PCMH evidence/credit (for applicable criteria) if the payer represents 75 percent of a center's patient population. Centers can use the additional time and resources they once dedicated to PCMH data collection and reporting for staff education, performance improvement and patient engagement.

3. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

SECTION 5

NCQA PCMH and SDOH Alignment

Centers care for patient populations with unique characteristics and SDOH that create significant health disparities. The Centers for Disease Control and Prevention defines SDOH as the social structures, physical structures, educational systems and economic systems that lead to inequalities in health access and health outcomes.[1] Healthy People 2020 identifies the following domains as key SDOH:

- **Economic Stability.**
- **Education.**
- **Social and Community Context.**
- **Health and Health Care.**
- **Neighborhood and Built Environment.**[2]

These domains are influenced by the distribution of money, power and resources in communities, states, nations and the world.[3] The Health Center Program Compliance Manual requires centers to assess their patient populations and identify SDOH and health disparities. Similarly, NCQA's PCMH Recognition program considers identifying, assessing and addressing SDOH as a fundamental component of the medical home transformation process. This section will help your health center identify and utilize NCQA PCMH and HRSA requirements to address SDOH and close the health disparities gap.

1. NCHHSTP Social Determinants of health available at: https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html {Accessed 1 December 2019].
2. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
3. CHHSTP Social Determinants of health available at: https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html {Accessed 1 December 2019].

NCQA PCMH and SDOH

Several NCQA PCMH concepts have core and elective criteria that emphasize the importance of identifying SDOH and collecting SDOH data to improve gaps in care. Table 1 illustrates the concepts that prioritize SDOH.

TABLE 1: PCMH RECOGNITION PROGRAM AND SDOH

Competency	Criterion	Additional Information
Knowing and Managing Your Patients (KM)		
A: Collecting Patient Information	KM 02: Comprehensive Health Assessment (core) KM 07: SDOH	Understands SDOH for patients, monitors at the population level and implements care interventions based on these data.
B: Patient Diversity	KM 11: Population Needs	Identifies and addresses population-level needs based on the diversity of the health center and the community.
F: Connecting with Community Resources	KM 21: Community Resource Needs	Uses information on the population served by the health center to prioritize needed community resources.
Patient Access and Continuity (AC)		
A: Patient Access to the Health Center	AC 09: Equity of Access	Uses information about the population served by the health center to assess equity of access that considers health disparities.
Care Management and Support (CM)		
A: Identifying Care Managed Patients	CM 01: Identifying Patients for Care Management	Uses information about the population served by the health center to assess equity of access that considers health disparities.
Performance Measurement and Quality Improvement (QI)		
A: Measuring Performance	QI 05: Health Disparities Assessment	Assesses health disparities using performance data stratified for vulnerable populations.
B: Setting Goals and Acting to Improve	QI 13: Goals and Actions to Improve Disparities in Care/Service QI 14: Improved Performance in Care/ Service	

Identifying and Assessing SDOH

Centers are required to develop a Needs Assessment that identifies SDOH factors that are assets or barriers to health care access, health care utilization and positive health outcomes. The assessment also provides specific incidence and prevalence data on chronic conditions and health disparities in the center's service area. community.

The PCMH concept *Knowing and Managing Your Patients (KM)* requires health centers to provide comprehensive health assessments for patients (KM 02) that identify behaviors affecting health and SDOH.

In practice, this is accomplished by ensuring that:

- The health center's EHR has templates to identify SDOH that could influence health outcomes.
- Health center staff receive education on the importance of capturing SDOH data.
- Clinical workflows are developed to ensure that SDOH data are captured for all patients and reviewed at pertinent visits.
- Clinical workflows allow support staff (e.g., nursing, community health workers, patient navigators) to collect SDOH data.

Table 2 identifies examples of SDOH data to collect in the EHR.

TABLE 2: ITEMS CONTRIBUTING TO HEALTH DISPARITIES

EHR Template Categories				
Behaviors affecting health	**SDOH**	**Communication needs**	**Language needs**	**Patient characteristics**
Examples (not exhaustive)				
• Tobacco use • EtOH use • Illicit substance use Sexual behavior • Physical activity • Mental health status	• Level of education • Employment status • Income level • Insurance status • Occupation • Housing Transportation • Social support structures • Primary/typical nutrition/diet • Veteran status • Citizenship status (refugee)	• Vision • Hearing	• Preferred written language • Preferred spoken language	• Race • Ethnicity • Sexual orientation • Gender identify

Many centers have used the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) tool developed by the National Association of Community Health Centers and its partners to capture SDOH patient data.[4] PRAPARE is available on paper and in some EHR systems.

Centers use SDOH data to determine health disparities in their patient populations. HRSA UDS reporting requires centers to report clinical quality measures that may reflect disparities based on SDOH (Race and/or Ethnicity) in UDS Table 7.[5]

Similarly, AC 09, in the NCQA PCMH *Access and Continuity (AC)* concept, provides credit to health centers that identify access to care inequities based on SDOH categories.

In practice, reporting demonstrates that:

- Patients citing transportation challenges have higher no-show appointment rates than patients with reliable transportation.
- Patients whose preferred language is not English have higher ED utilization rates than patients whose preferred language is English.

Managing Patients and Closing the Gap

After SDOH are recognized, centers can identify patients who may benefit from care management. The definition of care management, and the personnel who perform it, can vary between organizations; however, there is general consensus that care management is a comprehensive model of care that uses focused outreach to identify and manage patients at high risk for poor outcomes and overutilization.[6] Identified patients receive medical, behavioral and psychosocial assessments to guide interventions to improve their health literacy and health outcomes.[7]

Care management programs can be structured in a variety of ways. The medical home model requires care management staff to partner with patients/families/caregivers to develop a patient plan of care.

CM 01, in the *Care Management and Support (CM)* concept, requires health centers to have a process for identifying patients for care management. SDOH are possible elements of the identification process.

In order to close the health disparities gap, centers require performance measurement and quality improvement initiatives using SDOH data. Criteria in the *Performance Measurement and Quality Improvement (QI)* concept require SDOH or disparity data.

An SDOH/health disparities assessment might include:

- Patient experience data results identifying patients based on language needs.
- Diabetes clinical quality data for patients reporting Hispanic/Latino ethnicity.
- Influenza vaccine status based on education level.

4. PRAPARE. Available at: http://www.nachc.org/research-and-data/prapare/ [Accessed 16 December 2019].
5. Bphcdata.net. (2019). Uniform Data System: Reporting Instructions for the 2019 Health Center Data. [online] Available at: http://www.bphcdata.net/docs/uds_rep_instr.pdf [Accessed 1 Dec. 2019].
6. 2018 CPC+ Implementation Guide: Guiding Principles and Reporting. (2018, January 30). Retrieved from https://health.maryland.gov/mdpcp/Documents/.
7. Hong, C. S., Siegel, A. L., & Ferris, T. G. (2014). Caring for High-Need, High-Cost Patients: What Makes for a successful Care Management Program? The Commonwealth Fund: Issue Brief, 19, 1-19. Retrieved September 14, 2018.

After analyzing results, centers can set goals and actions to improve; for example:

- Patient experience data indicates that patients who do not identify English as their preferred language have poor experiences. *Improvement actions:*
  - Provide educational materials in patients' preferred languages.
  - Provide more onsite or virtual interpretation/translation services.
- Diabetes clinical quality data is poor for patients reporting Hispanic/Latino ethnicity. *Improvement actions:*
  - Prioritize care management activities for this patient population.
  - Provide educational materials in Spanish.
  - Recruit health center staff with similar ethnicity to participate in care management activities and outreach.
- There is a direct correlation between low flu vaccination compliance and patients with a high-school diploma (compared with college-educated patients). *Improvement actions:*
  - Implement patient-friendly flu education and campaigns.
  - Use multiple methods of educating patients on the benefits of the flu vaccine (e.g., social media, office videos, texts).

Conclusion

The NCQA PCMH model demonstrates the importance of identifying and addressing SDOH to improve patient engagement in their care and the quality of care delivered.

Addressing SDOH helps centers and PCMHs move toward reducing health disparities, thereby advancing health equity. By complying with HRSA guidelines, centers are well-equipped to successfully address SDOH and health disparities and well-positioned to attain and maintain the medical home model of care as outlined by NCQA.

SECTION 6

Recognition Process

Recognition for New Health Centers and Additional Site(s)

1. Confirm that NCQA Recognition is right for your health center by reviewing the **Standards and Guidelines** and the **Resources to Support Transformation**.
2. Submit a NOI to HRSA.
3. Start implementing changes to align with the NCQA PCMH standards.
4. Enroll in the **Q-PASS system**.
5. Have a kick-off call with your assigned NCQA representative.
6. Apply PCMH criteria to your health center.
7. Have up to three virtual reviews.
8. Submit for Recognition.
9. Earn Recognition.
10. Annual Reporting

Renewal for Recognized Centers

July prior to the reporting year

Download and review the updated **Annual Reporting Requirements**.

> Annual Reporting is more manageable and ensures accountability, because it is a continuous 'live' process.
>
> **Salud Para La Gente**

6–9 months before the Annual Reporting Date:

- Submit an NOI to HRSA for Annual Reporting.
- Select the option for which your health center would like to submit.
- Start gathering evidence for Annual Reporting requirements.
- Submit information to Q-PASS:
  - Confirm clinicians and health center information.
  - Upload documents and enter data to meet requirements.
  - HRSA will pay the Annual Reporting fee directly once your NOI is approved.

Annual Reporting Date

(1 month before Anniversary Date)

Submit Annual Reporting requirements.

SECTION 7

Resources to Support Transformation

NCQA provides a variety of support to ensure your health center can pursue and maintain PCMH Recognition without diverting time and energy from patient care. Below you will find resources for transformation relevant to health centers.

To see all resources related to PCMH Recognition, please visit Support for Transformation in the **Getting Started with NCQA Patient-Centered Medical Home Recognition** toolkit.

Instructions for Submitting NOI to HRSA

HRSA contracts with NCQA to provide technical support for the Recognition process. HRSA's support allows your health center to pursue PCMH Recognition and renewal without taking funds from patient care.

To initiate NCQA PCMH Recognition, health centers must first notify HRSA of their intent to participate by submitting a NOI in the HRSA Electronic Handbook (EHB) System. Specifically, your health center will need to follow these steps:

- In the EHB, go to the Grant Folder and click the **HRSA Accreditation/PCMH Initiative** link.
- Select **NCQA** in the Recognition organization list when completing the NOI.
- Make sure to provide information on the total number of sites requesting Recognition.
- Submit the NOI when it is completed. Allow 2–4 weeks for HRSA to complete the review. Once the NOI is approved, HRSA will forward the notice to NCQA for processing.

For more specific instructions, visit the **HRSA website**.

After NCQA has processed the approved NOI, your health center will receive an email with details to complete three time-sensitive steps. This message will contain the necessary guidance for you to begin your medical-home journey with NCQA!

Enrolling in the PCMH Program Through Q-PASS

You will have 30 days from the date in the welcome email to enroll your center into **Q-PASS** and begin the transformation process. On average, it takes centers 8-12 months after enrollment to complete the Recognition process, so it is important that your center jumps right into the process after your NOI is approved.

For detailed instructions on enrolling in the PCMH program through Q-PASS, please refer to Appendix A: Recognition through Q-PASS in the **Getting Started with NCQA Patient-Centered Medical Home Recognition** toolkit.

How to obtain your HRSA Discount Code

1. You should have received an email from NCQA directing you to the **Download Center**. Click on the link to the Download Center.
2. In the Download Center, download the Welcome Letter.
3. The Welcome Letter includes the discount code that you will need to create an invoice.

Use the HRSA Discount Code to Create the Invoice

1. You should have received a NCQA HRSA discount code (see instructions above). Click **Apply Discount** and enter the code in the field. Click **Apply Discount Now**. Once the code is entered, you will receive a message stating that the code is pending approval. Discount codes are approved within 5-7 business days.
2. Click **Create Invoice**.
3. Your order number displays—this is your invoice number. There should be no payment due if you entered the HRSA discount code. Click the order number to complete the transaction.
4. A screen displays with your enrollment information. Click **Complete Enrollment**.

What's Next?

You will receive an email with information about your NCQA Representative and next steps in earning NCQA PCMH Recognition. Your NCQA representative will contact you to set up your kick-off call.

Tips to Avoid a Stall in Your PCMH Transformation Process

1. PCMH transformation is an important process that will require a time commitment. It's important to stay on top of the process to ensure that you don't stall and miss important deadlines. Have a transformation timeline set when you enroll and adjust it after each check-in, based on Evaluator feedback.
2. NCQA is here to help with your PCMH transformation. The sooner you let us know your questions, the better we'll be able to help. Be sure to communicate any operational issues or causes of potential delay to NCQA, via your representative, as early as possible.
3. You don't have to go at the PCMH transformation process alone. Reach out for help, especially in content areas in which you may be facing challenges – you can get NCQA policy department input before your first check-in even occurs.
4. Build confidence in your transformation process by knocking out the work you already have in place. Aim for "low-hanging fruit" for your early check-in(s) – address operational aspects in which you already have mature processes.
5. Use your first two check-ins to present processes, even if you think they may not yet meet standards – the Evaluator can provide guidance on what's missing.

> "Transformation is a big change, but in the end PCMH requirements become the 'norm'.
>
> **Mainline Health Systems**

APPENDIX A
Glossary

Annual Recognition Fee	Annual fee paid to NCQA before the Annual Reporting submission.
Annual Reporting	A yearly check-in with NCQA, during which a health center demonstrates that its ongoing activities are consistent with the PCMH model of care. Includes attesting to policies and procedures and submitting data. The process sustains Recognition and fosters continuous improvement.
CAHPS®	Consumer Assessment of Health Providers and Systems®. An AHRQ program designed to advance scientific understanding of patient experience with healthcare. Health centers can work with state Medicaid programs and/or MCOs to review aggregate CAHPS questionnaire results in an effort to identify and improve performance at the center level.
CCE	Certified Content Expert. A PCMH expert and partner for health centers that want to improve patient care through transformation into an NCQA-Recognized PCMH. Candidates must complete two NCQA education seminars before applying for PCMH Content Expert Certification and pass the certification exam.
clinician	Must meet one of the following criteria: • Hold a current, unrestricted license as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN) or physician assistant (PA). • Physicians, APRNs (including nurse practitioners and clinical nurse specialists) and PAs who practice internal medicine, family medicine or pediatrics, with the intention of serving as the personal clinician for their patients.
competency	Part of the NCQA PCMH standards and guidelines. A way to categorize criteria.
concept	Part of the NCQA PCMH standards and guidelines. There are six concepts; they are the overarching themes of PCMH Recognition Standards. Health centers must complete criteria in each concept area.
Content Expert Certification	Highlights comprehensive knowledge of the PCMH Recognition requirements, application process and documentation. Holders of this certification are Certified Content Experts (CCE).
core criteria	Requirements that must be met in order to earn NCQA PCMH Recognition. There are 40 core criteria across 6 concept areas.

criterion	Part of the NCQA PCMH standards and guidelines. Health centers must pass all 40 core criteria and at least 25 credits of elective criteria.
documentation	A health center may submit documents through Q-PASS to demonstrate that it meets criteria. Some criteria allow virtual review.
elective criteria	Specific activities a health center may perform for NCQA PCMH Recognition. There are 60 elective criteria worth 1 or 2 credits each; the health center must meet 25 credits across at least 5 concept areas.
evaluator	An NCQA policy expert who reviews a health center's evidence and conducts virtual reviews. The evaluator determines whether the health center meets Recognition criteria. Health centers have the same evaluator for all check-ins during initial Recognition and for Annual Reporting.
evidence	Proof that a health center meets criteria. Evidence can be demonstrated by submitting documentation (e.g., policies and procedures, examples, data, reports) or through a virtual review of a health center's systems and electronic capabilities.
executive reviewer	An NCQA employee that works with NCQA representatives to answer content-related questions and resolve evaluation issues: • Reviews all evidence and conducts virtual reviews, if necessary, to provide feedback during check-ins. • Audits a percentage of Recognized health centers for evidence that they meet PCMH requirements. • Audits evaluators to ensure that they meet NCQA customer service and PCMH policy requirements.
Initial Recognition Fee	A fee paid (through Q-PASS or by check) upon enrollment in the NCQA PCMH Recognition program.
MACRA	The Medicare Access and CHIP Reauthorization Act of 2015. Replaced the Sustainable Growth Rate formula for how CMS pays clinicians who care for Medicare beneficiaries in the traditional Medicare program. Becoming an NCQA-Recognized PCMH directly increases clinicians' payments through the MIPS payment program. Clinicians in NCQA-Recognized PCMHs automatically get full credit in the MIPS CPIA category. Clinicians in NCQA-Recognized PCMH health centers will likely do well in other MIPS categories.
MCO	Managed Care Organization. An organization that accepts a set per member per month payment for Medicaid health benefits and additional services through contracted arrangements with Medicaid agencies.
met	The health center satisfied the requirements of specific criteria.
MOC	Maintenance of Certification. A program that provides clinicians with a pathway to know that they are staying current in the medical knowledge they use to treat patients. More than 95 organizations support NCQA Recognition by providing MOC credit.

multi-site organization	An organization with three or more health center sites that share an EHR and general policies and procedures ("site group"). Multi-site organizations may have more than one site group. The first site that goes through the Recognition process submits evidence that is shared among sites.
My.NCQA.org	A web-based portal for submitting questions to NCQA staff.
NCQA	National Committee for Quality Assurance. An organization that creates and measures quality standards for health plans, medical providers and practices. NCQA has the most widely used medical home model and Recognition program.
NCQA representative	An NCQA employee who guides a health center through Recognition and is the point of contact throughout the process, and after. Representatives also coordinate the annual check in.
NOI	Notice of Intent. A notice submitted by health centers through the Electronic Handbook (EHB) System, alerting HRSA of their intent to participate in the NCQA PCMH Recognition Program.
not met	The health center does not satisfy requirements of specific criteria and must resubmit information.
organization	A legal entity that has an individual that is capable of signing legal documents on behalf of all the health center sites within their organization.
organization administrator	An organization employee who sets up and administers an organization in Q-PASS.
OSV	Operational Site Visit. A review of a center's compliance with statutory and regulatory standards based on the Health Center Program and Compliance Manual.
Partner in Quality	An organization that offers coaching or financial incentives for health centers to become Recognized.
Patient-Centered Connected Care	An NCQA Recognition program that supports clinical integration and communication, creating a roadmap for how sites that deliver intermittent or outpatient treatment—but are not the primary care provider for a majority of patients—can communicate and connect with primary care and fit into the medical home "neighborhood."
patient-centered medical home	A primary care health center that is accountable for meeting a majority of patients' physical and mental health care needs, including prevention and wellness, acute and chronic care, with the goal of delivering high-quality, patient-centered care that lowers costs, improves patient experience and leads to better health outcomes.
Patient-Centered Specialty Health Center	An NCQA Recognition for a specialty health center that collaborates with primary care practices to streamline and improve health care delivery, with the goal of providing better care and an improved patient experience while reducing costs.
PCS	Policy Clarification and Support system. A subset of "Ask A Question" in My.NCQA.org that lets NCQA customers ask questions of NCQA staff.
PRAPARE	Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences. A tool developed by the National Association of Community Health Centers and its partners to capture SDOH patient data.

health center manager	A health center site employee who meets with the NCQA evaluator and submits evidence.
Health Center Program Compliance Manual	A HRSA manual that provides the statutory and regulatory requirements for which health center grantees must demonstrate compliance.
health center site	A physical location where one or more clinicians practice medicine. NCQA awards Recognition status to a health center site.
HRSA	Health Resources and Services Administration. A federal agency of the Department of Health and Human Services committed to improving access to health care for limited resourced communities.
PCMH	Patient-centered medical home. A model of organizing primary care medical practices that uses team-based care to improve access, quality, care management and care coordination.
prevalidation	Determines whether a health IT solution aligns with NCQA PCMH Recognition and whether automatic credit can be awarded. A health IT solution that earns prevalidation status but not automatic credit can still help a health center meet requirements.
Q-PASS	Quality Performance Assessment Support System. A web-based platform for submitting information to NCQA throughout the Recognition process and beyond.
screen sharing	Many criteria can be demonstrated through screen sharing instead of by submitting documentation. At each check-in during transformation, NCQA and the health center use Microsoft Skype™. Skype screen sharing is a Microsoft service covered under a Business Associate Agreement and audited by accredited independent auditors for the Microsoft ISO/IEC 27001 Certification. NCQA does not record the Skype sessions or download or save files shared during check-in.
SDOH	Social Determinants of Health. The social structures, physical structures, educational systems and economic systems that lead to inequalities in health access and health outcomes. Identifying, assessing and addressing SDOH is a fundamental component of the PCMH medical home transformation process.
shared evidence	Aggregate-level data or primary site/largest site data used only when criteria specify that "shared evidence" is acceptable for a multi-site submission.
single-site organization	An organization that has one or two health center sites, or many sites, but does not meet criteria to be Recognized under the multi-site process. See multi-site organization.
site group	A group of health center sites that can share components. By default, every multi-site organization has a site group comprising all health center sites set up in the organization.
succeed	The third stage of NCQA Recognition. After a health center earns Recognition, there is a yearly check-in with NCQA to demonstrate that its ongoing activities are consistent with the PCMH model of care. This process sustains the Recognition and fosters continuous improvement. The health center succeeds in strengthening its transformation, and as a result, strengthening patient care.

transfer credit	Credit toward a certain number of core or elective criteria, earned automatically by using a prevalidated vendor's EHR system.
transform	The second phase of NCQA PCMH Recognition, during which a health center becomes a medical home. During this process, NCQA conducts online check-ins with to gauge the health center's progress and to discuss next steps in the evaluation. Virtual check-ins provide health centers with immediate, personalized feedback.
UDS	Uniform Data System. Data used to review and evaluate the operational, financial and clinical quality performance of centers.

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