

Phase Aspects:	Phase Description:	Phase Milestones:	PCMH Elements	Meaningful Use Elements (Stage 2)
Phase 1: Setting aims and developing basic				
PCMH 2014 Standards/Stage 2 MU Goals			PCMH 1: Patient-Centered Access: The practice provides access to team-based care for both routine and urgent needs of patients/ families/ caregivers at all times. 10 points PCMH 2: Team-Based Care: The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches. 12 points PCMH 3: Population Health Management: The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population. 20 points PCMH 4: Care Management and Support: The practice systematically identifies individual patients and plans, manages and coordinates care, based on need. 20 points PCMH 5: Care Coordination and Care Transitions: The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations. 18 points PCMH 6: Performance Measurement and Quality Improvement 20 points	Goal A: Improve quality, safety, efficiency, & reduce health disparities Goal B: Engage Patients and Families Goal C: Improve Care Coordination Goal D: Improve Population and Public Health Goal E: Ensure Adequate Privacy & Security Protection for PHI
Goal setting and planning	The practice has the full support of leadership for transformation and develops and commits to a clear statement that outlines the specific goals of transformation, why they are important to the practice and the community they serve, what changes will be made, and how progress will be measured.	Practice will submit a detailed plan that addresses the specific goals of transformation—what is important to the practice and the aims. This will be submitted within one month of practice joining PTN.	MUST-PASS: Element 6D: Implement Continuous Quality Improvement 4 points The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least three clinical quality measures from Element A 2. Act to improve at least three clinical quality measures from Element A 3. Set goals and analyze at least one measure from Element B 4. Act to improve at least one measure from Element B 5. Set goals and analyze at least one patient experience measure from Element C 6. Act to improve at least one patient experience measure from Element C 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations	

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Practice self-assessment		Practice starts to perform a self-assessment and starts to collect baseline data on utilization and other quality and outcome measures and identifies problem areas for improvement.		
Training on care model	Learns and integrates a planned care model which includes understanding the intersection of administrative, financial, and clinical systems and uses this knowledge to redesign all of these processes toward a leaner and higher performing organization that produces better outcomes.	Practice starts to train at least 50% of staff in improvement methods and tools. Staff starts to understand the process of improvement and how to test changes in daily workflows. Staff is trained on optimal team-based practice.		
Data integration into improvement process	Uses data to better understand practice flow. Implements improvement strategy that relies on routine performance measurement to identify opportunities for improvement and uses rapid cycle change methods to test ideas for change. Intentionally minimizes unnecessary testing and procedures, and measures, and reports impact of these changes.	Practice has a process in place for training staff on data quality problems when they are detected. Practice establishes measures, plans and a baseline for intentionally minimizing unnecessary testing and procedures.	Element 6A: Measure Clinical Quality Performance 3 points At least annually, the practice measures or receives data on: 1. At least two immunization measures 2. At least two other preventive care measures 3. At least three chronic or acute care clinical measures 4. Performance data stratified for vulnerable populations (to assess disparities in care).	
HIE Participation	Bi-directional HIE participation for specialists			
Learning collaborative participation	Participates in learning collaborative to share its best practices and lessons learned and to benefit from the learning of others.			

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Patient and family-centered care.	Practice recognizes importance of patient and family engagement in care.	Practice has in place mechanisms for addressing the needs of their patients/families to be active partners in care.	<p>Element 2A: Continuity 3 points</p> <p>The practice provides continuity of care for patients/families by:</p> <ol style="list-style-type: none"> 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team 3. Having a process to orient new patients to the practice 4. Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care 	
Accommodating Cultural Diversity			<p>Element 2C: Culturally and Linguistically Appropriate Services 2.5 points</p> <p>The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:</p> <ol style="list-style-type: none"> 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population 	
Integration of Medical Home aspects into clinical operations			<p>Element 2B: Medical Home Responsibilities 2.5 points</p> <p>The practice has a process for informing patients/ families about the role of the medical home and gives patients/families materials that contain the following information:</p> <ol style="list-style-type: none"> 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice 4. The care team provides access to evidence-based care, patient/family education and self-management support 5. The scope of services available within the practice including how behavioral health needs are addressed 	

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Integration of Medical Home aspects into clinical operations (continued)			6. The practice provides equal access to all of their patients regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage 8. Instructions on transferring records to the practice, including a point of contact at the practice	
Phase 2: Reporting and using data to generate improvements				
Integration of Population Health Management Model	Acquires core capabilities in improving the health of populations through more cost-effective systems of care.	Executive and staff training on Population Health model.		
Progression toward Meaningful Use and integration of HIT			Element 3A: Patient Information 3 points The practice uses an electronic system to records patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients. Element 3B: Clinical Data 4 points The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data. Element 6G: Use Certified EHR Technology Not Scored The practice uses a certified EHR system	Core 1: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. Core 3: Record the following demographics: preferred language, sex, race, ethnicity, date of birth. Core 4: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI. Core 5: Record smoking status for patients 13 years old or older. Core 10: Incorporate clinical lab-test results into Certified EHR Technology as structured data. Menu 2: Record electronic notes in patient records.

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Electronic access to health information			<p>Element 1C: Electronic Access 2 points</p> <p>The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system.</p> <ol style="list-style-type: none"> 1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+ 2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+ 3. Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits+ 4. A secure message was sent to more than 5 percent of patients+ 5. Patients have two-way communication with the practice 6. Patients can request appointments, prescription refills, referrals and test results <p>+Stage 2 Core Meaningful Use Requirement</p>	<p>Core 7: Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.</p> <p>Core 17: Use secure electronic messaging to communicate with patients on relevant health information.</p>
Integration of E- Prescribing			<p>Element 4D: Use Electronic Prescribing 3 points</p> <p>The practice uses an electronic prescription system with the following capabilities.</p> <ol style="list-style-type: none"> 1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies+ 2. Enters electronic medication orders in the medical record for more than 60 percent of medications+ 3. Performs patient-specific checks for drug-drug and drug-allergy interactions+ 4. Alerts prescriber to generic alternatives <p>+ Stage 2 Core Meaningful Use Requirement</p>	<p>Core 2: Generate and transmit permissible prescriptions electronically (eRx).</p>
HIPAA Privacy and Security Compliance				<p>Core 9: Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.</p>

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Care Coordination and Management Agreements	Establishes new relationships within the community and expands the care team.	Practice has identified community partners and other points of care that their patients are using and has a formal agreement in place with these partners. Care Coordination and Co-Management agreements covering at least 15% of patients for specialists.	<p>MUST-PASS CRITICAL FACTOR = FACTOR 8</p> <p>Element 5B: Referral Tracking and Follow-Up 6 points</p> <p>The practice:</p> <ol style="list-style-type: none"> 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+ 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports 9. Documents co-management arrangements in the patient's medical record 10. Asks patients/families about self-referrals and requesting reports from clinicians <p>+ Stage 2 Core Meaningful Use Requirement</p>	

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Use of Care Teams			MUST-PASS CRITICAL FACTOR = FACTOR 3 Element 2D: The Practice Team 4 points The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population	
Use of Care Teams (Continued)			8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	
Health Risk Assessments			Element 3C: Comprehensive Health Assessment 4 points To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment	

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Test Tracking			<p>CRITICAL FACTORS = FACTORS 1 AND 2 Element 5A: Test Tracking and Follow-Up 6 points The practice has a documented process for and demonstrates that it:</p> <ol style="list-style-type: none"> 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults) 7. More than 30 percent of laboratory orders are electronically recorded in the patient record+ 8. More than 30 percent of radiology orders are electronically recorded in the patient record+ 9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record+ 10. More than 10 percent of scans and tests that result in an image are accessible electronically++ + Stage 2 Core Meaningful Use Requirement ++ Stage 2 Menu Meaningful Use 	<p>Menu 3: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.</p>

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Use of Population Health Level Data	Produces real time reports on how practices, providers and care teams are meeting quality, financial and utilization goals to enhance patient experience of care, eliminate waste and decrease costs.	Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement and resulting in reduced unnecessary tests and hospitalizations.	<p>MUST-PASS: Element 3D: Use Data for Population Management 5 points</p> <p>At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:</p> <ol style="list-style-type: none"> 1. At least two different preventive care services+ 2. At least two different immunizations+ 3. At least three different chronic or acute care services+ 4. Patients not recently seen by the practice 5. Medication monitoring or alert <p>+ Stage 2 Core Meaningful Use Requirement</p>	<p>Core 6: Use clinical decision support to improve performance on high-priority health conditions.</p> <p>Core 11: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p>
Participates in HIE to improve outcomes and reduce cost		Practice has defined improvements in care transition and processes enabled through exchange of essential health information to eliminate waste and decrease costs.	<p>Element 6B: Measure Resource Use and Care Coordination 3 points</p> <p>At least annually, the practice measures or receives quantitative data on:</p> <ol style="list-style-type: none"> 1. At least two measures related to care coordination 2. At least two measures affecting health care costs 	<p>Core 15: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary care record for each transition of care or referral.</p> <p>Core 16: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.</p>

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Outcome reporting and patient specific care plans	Shares outcomes of quality and clinical measures for the patient population with the PTN. Uses data to analyze potential disparities in care and develops action plans—this allows practices to identify individual patients needing intervention to improve overall practice performance.		Element 6E: Demonstrate Continuous Quality Improvement 3 points The practice demonstrates continuous quality improvement by: <ol style="list-style-type: none"> 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 2. Achieving improved performance on at least two clinical quality measures 3. Achieving improved performance on one utilization or care coordination measure 4. Achieving improved performance on at least one patient experience measure Element 6F: Report Performance 3 points The practice produces performance data reports using measures from Elements A, B and C and shares: <ol style="list-style-type: none"> 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice 3. Individual clinician or practice-level performance results publicly 4. Individual clinician or practice-level performance results with patients 	Core 12: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference. Core 13: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient. Menu 1: Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice. Menu 5: Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. Menu 6: Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.
Patient and care team empanelment		At least 50% of the practice’s patients have a main clinical point of contact at the practice for their health care needs (i.e. empanelment to provider and care teams).		
Specialty care coordination	Practice has integrated specialty care through agreements.			

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Patient and family engagement	The practice identifies ways to increase patient and family engagement in care and identifies barriers to patient and family engagement in care.		Element 4E: Support Self-Care and Shared Decision Making 5 points The practice has, and demonstrates use of, materials to support patients and families/ caregivers in self-management and shared decision making. The practice: 1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+ 2. Provides educational materials and resources to patients 3. Provides self-management tools to record self-care results 4. Adopts shared decision making aids 5. Offers or refers patients to structured health education programs such as group classes and peer support 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources. + Stage 2 Core Meaningful Use Requirement	Core 8: Provide clinical summaries for patients for each office visit. Menu 4: Record patient family health history as structured data.
Utilization review	The practice tracks patients obtaining outside services.			
Meaningful Use Plan	Eligible clinicians assess their ability to meet Meaningful Use objectives and develop an EHR integration plan to meet Meaningful Use objectives in Phase 5.			
Continuous Access to Care Team			CRITICAL FACTOR = FACTOR 2 Element 1B: 24/7 Access to Clinical Advice 3.5 points The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on: 1. Providing continuity of medical record information for care and advice when the office is closed 2. Providing timely clinical advice by telephone 3. Providing timely clinical advice using a secure, interactive electronic system 4. Documenting clinical advice in patient records	

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Use of Evidence-based clinical reminders			CRITICAL FACTOR = FACTOR 1 Element 3E: Implement Evidence-Based Decision Support 4 points The practice implements clinical decision support + (e.g. point-of-care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder 2. A chronic medical condition 3. An acute condition 4. A condition related to unhealthy behaviors 5. Well child or adult care 6. Overuse/appropriateness issues	
Care Management for At-Risk Patients		The practice provides care management to at least 50% of highest risk patients (those that are clinically unstable).	Element 4A: Identify Patients for Care Management 4 points The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria	
Care Management Processes		The practice implements at least three specific care management strategies for patients in higher risk cohorts, samples may include, but are not limited to: o Integration of behavioral health, o Self-management support for at least three high risk conditions o Medication management and review.		

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Risk Stratification and Population Health Data Use		Monthly reporting includes updating information about the practice's risk stratification methodology, empanelment status, risk stratification data, and other activities.		
Continuous Improvement Process integrates PDSA Cycle		Practice incorporates regular improvement methodology to execute change ideas in a rapid cycle. Use a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.		
Phase 3: Achieving aims of lower costs, better care, and better health				
Maturity in Care Team Model	Optimizes care team and utilizes technology to track patient improvements via population based management (use of information on clinical grouping of patients to improve their care and clinical outcomes). Matches and allocates care team functions based on skill, abilities, and credentials to support efficient care delivery.	Practice is optimizing reports in registry, practice management, or EHR system to drive clinical practice improvement on a monthly basis. Practice sets clear expectations for each team member's functions and responsibilities to optimize efficiency, outcomes, and accountability.		

<p>Integration of Patient Experience and Staff feedback into CQI process and link to performance incentives</p>	<p>Obtains feedback from patients and family members about their health care experience and uses this information for quality improvement. Provides incentives to care team based on performance.</p>	<p>Practice has involved patients, families and staff in quality improvement initiatives.</p>	<p>Element 6C: Measure Patient/Family Experience 4 points At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: · Access · Communication · Coordination · Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool 3. The practice obtains feedback on experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means</p>	
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Use of Patient Self-Management Processes and Goal Setting	Proactively engages patients and families to expand their role in decision making, health-related behaviors and self-management.	Practice routinely creates and/or maintains shared care plans and utilizes shared decision making tools to incorporate patient preferences and goals in care management processes.	MUST-PASS Element 4B: Care Planning and Self-Care Support 4 points The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A: 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/ caregiver	
Demonstrated Improved Outcomes	Demonstrates improvement on select quality measures.	Practice has reduced unnecessary tests and hospitalizations by at least 25% from baseline (15% for specialists). Practice has increased the number of patients who have received the appropriate health screenings and completion of referrals.		
Use of Risk Stratification to Address Gaps in Care	Practice identifies patient risk stratification by disease, health risk and other conditions.	Practice has identified high risk patients and has ensured they are receiving appropriate care and case management services. Practice has a formal written vision related to care coordination.		

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Medication Reconciliation and Management			<p>CRITICAL FACTOR = FACTOR 1 Element 4C: Medication Management 4 points</p> <p>The practice has a process for managing medications, and systematically implements the process in the following ways:</p> <ol style="list-style-type: none"> 1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions+ 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions 3. Provides information about new prescriptions to more than 80 percent of patients/families/ caregivers. 4. Assesses understanding of medications for more than 50 percent of patients/families/ caregivers, and dates the assessment 5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates <p>+Stage 2 Core Meaningful Use Requirement</p>	<p>Core 14: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p>
External Data Sharing		Practice routinely exchanges essential health information with other members of care team outside of the practice.		
Care Coordination and Management Agreements		Care Coordination and Co-Management Agreements covering at least 30% of patients for specialists.		
Use of Care Teams and Community Resources with Utilization Tracking		<p>Practice links a patient to a provider and care team so both the patients and team recognize each other as partners in care.</p> <p>Practice ensures that patients are able to see their provider or care team whenever possible.</p> <p>Practice links patients with community resources to facilitate referrals.</p> <p>Practice tracks and supports patients when they obtain services outside the practice.</p>		

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ER or Inpatient Follow-up for Care Transition		Practice follows up with patients within 24 hours after an emergency room visit or hospital discharge.	Element 5C: Coordinate Care Transitions 6 points The practice: 1. Proactively identifies patients with unplanned hospital admissions and emergency department visits 2. Shares clinical information with admitting hospitals and emergency departments 3. Consistently obtains patient discharge summaries from the hospital and other facilities 4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Exchanges patient information with the hospital during a patient’s hospitalization 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+ +Stage 2 Core Meaningful Use Requirement	
Phase 4: Getting to benchmark status				
Use of Data for Advanced Population Health Management	Manages populations of patients through a panel with significant demonstration of care coordination, including coordinating follow up appointments with patient after emergency room visits or hospitalizations.	Practice uses utilization reports on a monthly basis and continuously makes clinical improvement changes such as 24/7 access to care, ‘same as’ tracking number of patient triaged after hours, number of same day appointments for emergent problems, number of patients being discharged from the hospital and needing an appointment with 24 hours after discharge, and the practice continues to decrease the “no show” rate over time.		
Data reporting and utilization tracking	Provides patients with community resources, tracks and supports patients obtaining outside services.	Practices submit utilization reports to PTN on a monthly basis. Feedback is submitted back to the practice.		

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Enhanced Open Access	Integrates advanced access to eliminate waits, minimize “no show” rates and streamline workflow, such as 24/7 access to the care team, and scheduling options.		MUST-PASS CRITICAL FACTOR = FACTOR 1 Element 1A: Patient-Centered Appointment Access 4.5 points The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no show rates 6. Acting on identified opportunities to improve access	
Sustained Outcome Improvement	Continues to demonstrate improved performance on quality measures and seeks to improve performance relative to local and national benchmarks.	Practice has reduced unnecessary tests and hospitalizations by at least 20% from baseline (primary and specialty care). Practice has a process in place for identifying 90% of high risk patients on a monthly basis and has ensured that 75% are receiving appropriate care and case management services as part of their continuous practice improvement plan.		
Care Coordination and Management Agreements		Care Coordination and Co-Management Agreements covering at least 50% of patients for specialists.		
Medical Neighborhood Population Health Data Use	Has knowledge of the health status of other populations in the medical neighborhood and contributes to the success of the overall health of the community served.			

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Patient Tracking and Linkages		<p>Practice tracks patients, on a monthly basis, when they obtain services outside of the practice.</p> <p>Practice has a process in place to link the patient to a care provider and care team so both the patients and team recognize each other as partners in care.</p>		
Phase 5: Practice has demonstrated capability to generate better care, better health at lower cost.				
Sustained Outcome Improvement	Practice has documented substantial performance improvements. Practice generates significant quality improvements in patient health outcomes and experience of care.	Practice sustains prior improvements in key metrics for at least one year.		
Advance MU of HIT	Eligible clinicians have completed implementing their integration plans for meeting meaningful use objectives.			
Advanced Capacity to engage in Value-based Reimbursement Models		Practice has developed business acumen in the various types of alternative payment models including understanding of shared savings models with and without risk, various contracting arrangements that a practice might consider, and how to evaluate the pros and cons for the population they serve.		