

Qualidigm's Recommendations

February 17, 2015

1	A	B	C	D	
	Standard	Element & Factor		Comments	
3	Standard 1: Patient-Centered Access	<u>–Element A: Patient-centered appointment access. (MUST-PASS)</u>	●	We do not see any issues with Standard 1.	
4		1. Providing same-day appointments for routine and urgent care. (CRITICAL)	●		
5		2. Providing routine and urgent-care appointments outside regular business hours.	●		
6		3. Providing alternative types of clinical encounters.	●		
7		4. Availability of appointments.	●		
8		5. Monitoring no-show rates.	●		
9		6. Acting on identified opportunities to improve access.	●		
11			<u>–Element B: 24/7 Access to Clinical Advice</u>	●	
12			1. Providing continuity of medical record information for care and advice when office is closed.	●	
13			2. Providing timely clinical advice by telephone. (CRITICAL)	●	
14			3. Providing timely clinical advice using a secure, interactive electronic system.	●	
15			4. Documenting clinical advice in patient records.	●	
17			<u>–Element C: Electronic Access</u>	●	
18			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.	●	
19			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.	●	
20			3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits.	●	
21			4. A secure message was sent by more than 5 percent of patients.	●	
22			5. Patients have two-way communication with the practice.	●	

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23		6. Patients can request appointments, prescription refills, referrals and test results.	●
25	Standard 2: Team-Based Care	<u>–Element A: Continuity</u>	● We do not see any issues with Standard 2 Element A.
26		1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.	●
27		2. Monitoring the percentage of patient visits with selected clinician or team.	●
28		3. Having a process to orient new patients to the practice.	●
29		4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care. (NEW CRITICAL)	●
31		<u>–Element B: Medical Home Responsibilities</u>	● We do not see any issues with Standard 2 Element B.
32		1. The practice is responsible for coordinating patient care across multiple settings.	●
33		2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.	●
34		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.	●
35		4. The care team provides access to evidence-based care, patient/family education and self-management support.	●
36	5. The scope of services available within the practice including how behavioral health needs are addressed.	●	
37	6. The practice provides equal access to all of the patients regardless of source of patient.	●	
38	7. The practice gives uninsured patients information about obtaining coverage.	●	
39	8. Instructions on transferring records to the practice, including a point of contact at the practice.	●	

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41		<u>–Element C: Culturally and Linguistically Appropriate Services (NEW MUST-PASS)</u>	●	While this is not an NCQA Must Pass element, the PTF has recommended that this be a Must Pass Element. We do not foresee any issues as this aligns with Meaningful Use criteria. We recommend additional training via webinar on the CLAS standards.
42		1. Assessing the diversity of its population.	●	
43		2. Assessing the language needs of its population.	●	
44		3. Providing interpretation or bilingual services to meet the language needs of its population.	●	
45		4. Providing printed materials in the languages of its population.	●	
46		<i>–Area of Emphasis: (Standard 2: Element C)</i> <i>–The practice should be knowledgeable about culturally appropriate services in the practice’s catchment area and health disparities among patient populations served by the practice</i>	●	We do not see any issues with having this as an elective Area of Emphasis.
48		<u>–Element D: The Practice Team (MUST-PASS)</u>	●	
49		1. Defining roles for clinical and nonclinical team members.	●	
50		2. Identifying the team structure and the staff who lead and sustain team based care.	●	
51		3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL)	●	
52		4. Using standing orders for services.	●	

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53		5. Training and assigning members of the care team to coordinate care for individual patients.	●	We recommend adding two additional group trainings on care coordination principles, and one additional on-site visit with each practice. Through our needs assessment at both the organizational and practice level, we will be better able to identify practices and organizations that have already established some care coordination capabilities.
54		6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.	●	
55		7. Training and assigning members of the care team to manage the patient population.	●	
56		8. Holding scheduled team meetings to address practice functioning.	●	
57		9. Involving care team staff in the practice's performance evaluation and quality improvement activities.	●	
58		10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.	●	
59		<p><i>–Area of Emphasis: (Standard 2: Element D)</i></p> <p><i>–Implementation of Patient-Family Advisory Panels at the practice for quarterly feedback and continuous quality improvement. Patient-Family Advisory Panels will help to inform the practice team on how to provide better patient-centered care and improve patient satisfaction.</i></p>	●	The Task Force is considering making factor 10, "Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council," an elective Area of Emphasis for all practices. The QP team supports this recommendation. Our team will support a centralized pilot for the Advanced Network in creating an advisory panel.

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61	Standard 3: Population Health Management	<u>–Element A: Patient Information</u>	●	We do not see any issues with Standard 3 Element A.
62		1. Date of birth	●	
63		2. Sex.	●	
64		3. Race.	●	
65		4. Ethnicity	●	
66		5. Preferred language.	●	
67		6. Telephone numbers.	●	
68		7. E-mail address.	●	
69		8. Occupation (NA for pediatric purposes)	●	
70		9. Dates of previous clinical visits.	●	
71		10. Legal guardian/health care proxy.	●	
72		11. Primary caregiver.	●	
73		12. Presence of advance directives (NA for pediatric purposes)	●	
74		13. Health insurance information.	●	
75		14. Name and contact information of other health care professionals involved in patient's care.	●	
		<u>–Element B: Clinical Data</u>	●	We do not see any issues with Standard 3 Element B.
77			●	
78		1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.	●	
79		2. Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.	●	
80		3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.	●	
81		4. Height/length for more than 80 percent of patients.	●	
82		5. Weight for more than 80 percent of patients.	●	

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83		6. System calculates and displays BMI.	●	
84		7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices)	●	
85		8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.	●	
86		9. List of prescription medications with date of updates for more than 80 percent of patients.	●	
87		10. More than 20 percent of patients have family history recorded as structured data.	●	
88		11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.	●	
		<u>-Element C: Comprehensive Health Assessment (NEW MUST-PASS)</u>	●	
90		1. Age- and gender appropriate immunizations and screenings.	●	
91		2. Family/social/cultural characteristics	●	
92		3. Communication needs.	●	
93		4. Medical history of patient and family.	●	
94		5. Advance care planning (NA for pediatric purposes).	●	
95		6. Behaviors affecting health. (NEW CRITICAL)	●	
96			●	We recommend this not be a critical factor but an elective Area of Emphasis. We propose to assess practices' documentation of behaviors affecting health & how to improve documentation
97		7. Mental health/substance use history of patient and family. (NEW CRITICAL)	●	
98		8. Developmental screening using a standardized tool (NA for practices with no pediatric patients). (NEW CRITICAL)	●	

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99		9. Depression screening for adults and adolescents using a standardized tool. (NEW CRITICAL)	●	
100		10. Assessment of health literacy. (NEW CRITICAL)	●	We recommend this not be a critical factor in Phase I of the project. However, we will assess the current practices of the offices and their ability to assess health literacy. Based on this assessment, we will recommend additional support and training as Phase II.
101		<p>–Area of Emphasis (Standard 3: Element C: Factor 2 & 10)</p> <p><i>–Provide practices with training and support for evaluation and assessment of family/social/cultural characteristics and health literacy. Train practices to use this information to identify patients for care management and provide more individualized care incorporating a patients cultural norms, needs, and beliefs.</i></p>	●	We do not foresee any issues regarding the assessment of family/social/cultural characteristics. However, we have concerns regarding the assessment of health literacy, as noted for factor 10.
102		<p>–Area of Emphasis (Standard 3: Element C)</p> <p><i>–Instruct practices in the provision of age appropriate oral health risk and disease screening. The practice should be advised how to implement age appropriate oral health risk and disease assessment, Including assessments for caries, periodontal disease and oral cancer.</i></p> <p><i>–Instruct practices how to better understand the health risks and information needs of patients/families and train practices to perform an accurate, patient-centered, culturally and linguistically appropriate comprehensive health assessment.</i></p>	●	Oral Health Risk and Disease Screening - While this is not something that most practices have built into their workflow, we could recommend to the practices that this be part of their Comprehensive Preventive Health Screening. We could add an additional webinar/training that would include all preventive screenings for primary care practices, including oral health.
104		–Element D: Use Data for Population Management (MUST-PASS)	●	We do not see any issues with Standard 3 Element D.

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105		1. At least two different preventive care services.	●	
106		2. At least two different immunizations.	●	
107		3. At least three different chronic or acute care services.	●	
108		4. Patients not recently seen by the practice.	●	
109		5. Medication monitoring or alert.	●	
111		<u>–Element E: Implement Evidence-Based Decision Support (MUST-PASS)</u>	●	We do not see any issues with Standard 3 Element E.
112		1. A mental health or substance use disorder. (CRITICAL)	●	
113		2. A chronic medical condition.	●	
114		3. An acute condition.	●	
115		4. A condition related to unhealthy behaviors.	●	
116		5. Well child or adult care.	●	
117		6. Overuse/appropriateness issues.	●	
119	Standard 4: Care Management and Support	<u>–Element A: Identify Patients for Care Management</u>	●	
120		1. Behavioral health conditions. (CRITICAL)	●	Even though practices will be recruited that are part of an Advanced Network, it is likely that a number of challenges will present themselves related to behavioral health. These are likely to include: variability in screening practices, incompletely developed linkages between primary care and behavioral health professionals, and incomplete care management of medical and behavioral health conditions. Therefore, we recommend not identifying Factor 1 as a Critical Factor, but as an elective factor.
121		2. High cost/high utilization.	●	

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122		3. Poorly controlled or complex conditions.	●	
123		4. Social determinants of health.	●	
124		5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.	●	
125		6. The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL)	●	
126		<p>–Area of Emphasis (Standard 4: Element A)</p> <p><i>–Identify patients for care management that include 95% empanelment, with 75% risk stratification, and 80% of care management for high risk patients</i></p> <p><i>–Criteria for identifying patients for care management are developed from a profile of patient assessments and may include a combination of the following: A diagnosis of an oral health issue (e.g. oral health risk and disease assessment to include caries, periodontal disease and cancer detection); A positive diagnosis by a dentist of an oral disease condition or risk of the disease.</i></p>	●	Practices that are part of an Advanced Network will need to embrace the concepts of empanelment, risk stratification, and care management of high risk patients. However, Advanced Networks currently vary in their degree of adoption. We recommend not setting aspirational goals for implementation of these concepts until recruitment is completed and we fully understand baseline levels of implementation. We recommend working with the PMO and the PTF to set goals at that point.
128		–Element B: Care Planning and Self-Care Support (MUST-PASS)	●	
129		1. Incorporates patient preferences and functional/lifestyle goals. (CRITICAL)	●	We do not foresee any issues. This was already built into the proposal.
130		2. Identifies treatment goals.	●	
131		3. Assesses and addresses potential barriers to meeting goals.	●	
132		4. Includes a self-management plan.	●	
133		5. Is provided in writing to the patient/family/caregiver.	●	
135		–Element C: Medication Management	●	

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136		1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions. (CRITICAL)	●	
137		2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	●	
138		3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.	●	
139		4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.	●	
140		5. Assesses response to medications and barriers to adherence fore more than 50 percent of patients, and dates the assessment. (NEW CRITICAL)	●	We do not foresee any issues. This was already built into the proposal and aligns with Meaningful Use.
141		6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.	●	
		–Element D: Use Electronic Prescribing		
143			●	We do not see any issues with Standard 4 Element D.
144		1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.	●	
145		2. Enters electronic medication orders in the medical record for more than 60 percent of medications.	●	
146		3. Performs patient-specific checks for drug-drug and drug-allergy interactions.	●	
147		4. Alerts prescribers to generic alternatives.	●	
		–Element E: Support Self-Care and Shared Decision Making		
149			●	We do not see any issues with Standard 4 Element E.
150		1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.	●	
151		2. Provides educational materials and resources to patients.	●	
152		3. Provides self-management tools to record self-care results.	●	

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153		4. Adopts shared decision making aids.	●	
154		5. Offers or refers patients to structured health education programs, such as group classes and peer support.	●	
155		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.	●	
156		7. Assesses usefulness of identified community resources.	●	

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157		<p>–Area of Emphasis (Standard 4: Element E)</p> <p><i>–Focus on shared decision making communications between patient and practitioner (taking into account patient preferences) giving the patient the support they need to make the best individualized care decisions.</i></p> <p><i>–Improve educational materials and resources available to patients.</i></p> <p><i>–Identify two target health conditions for self-care and shared decision-making for the practice’s population</i></p>	●	We do not see any issues with having this as an elective Area of Emphasis
158		<p>–Area of Emphasis (Standard 4: Element A-E)</p> <p><i>–Focus on empathetic care and communication between practitioners and patient/families. Provide training for techniques and best practices to support patients and improve care experience.</i></p>	●	We do not see any issues with having this as an elective Area of Emphasis
160	Standard 5: Care Coordination and Care Transitions	–Element A: Test Tracking and Follow-Up	●	We do not see any issues with Standard 5 Element A.
161		1. Tracks lab tests until results are available, flagging and following up on overdue results. (CRITICAL)	●	
162		2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL)	●	
163		3. Flags abnormal lab results, bringing them to the attention of the clinician.	●	
164		4. Flags abnormal imaging results, bringing them to the attention of the clinician.	●	
165		5. Notifies patients/families of normal & abnormal lab and imaging test results.	●	
166		6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).	●	
167		7. More than 30 percent of laboratory orders are electronically recorded in the patient record.	●	
168		8. More than 30 percent of radiology orders are electronically recorded in the patient record.	●	

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169		9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.	●	
170		10. More than 10 percent of scans and tests that result in an image are accessible electronically.	●	
		<u>-Element B: Referral Tracking and Follow-Up (MUST-PASS)</u>		
172			●	We do not see any issues with Standard 5 Element B.
173		1. Considers available performance information on consultants/specialists when making referral recommendations.	●	
174		2. Maintains formal and informal agreements with a subset of specialists based on established criteria.	●	
175		3. Maintains agreements with behavioral healthcare providers.	●	
176		4. Integrates behavioral healthcare providers within the practice site.	●	
177		5. Gives the consultant or specialist the clinical question, the required timing, and the type of referral.	●	
178		6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.	●	
179		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.	●	
180		8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL)	●	
181		9. Documents co-management arrangements in the patient's medical record.	●	
182		10. Asks patients/families about self-referrals and requesting reports from clinicians.	●	

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183		<p><i>–Area of Emphasis (Standard 5: Element B)</i></p> <p><i>–Focus on the development of collaborative agreements with at least two groups of high-volume specialties to improve care transitions (NCQA requires one)</i></p> <p><i>–Focus on enabling the practice to track the percentage of patients with ED visits who receive follow-up</i></p>	●	We do not see any issues with having this as an elective Area of Emphasis.
185		<u>–Element C: Coordinate Care Transitions</u>	●	
186		1. Proactively identifies patients with unplanned hospital admissions and emergency department visits.	●	
187		2. Shares clinical information with admitting hospitals and emergency departments.	●	
188		3. Consistently obtains patient discharge summaries from the hospital and other facilities.	●	
189		4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.	●	
190		5. Exchanges patient information with the hospital during a patient’s hospitalization.	●	
191		6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care within community partners. (NEW CRITICAL)	●	This factor represents a small minority of patients because it addresses consent to share information with legal guardians or custodians. We recommend that this be an optional Area of Emphasis.
192		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.	●	

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193		<p><i>–Area of Emphasis: (Standard 5: Element C)</i></p> <ul style="list-style-type: none"> <i>–Proactively identifies patients with unplanned hospital admissions and emergency department visits</i> <i>–Shares clinical information with admitting hospitals and emergency departments</i> <i>–Practice responsible to contact 75% of patients who were hospitalized within 72 hours</i> 	●	We support the recommendation that these be core and elective Areas of Emphasis.
195	Standard 6: Performance Measurement and Quality Improvement	<u>–Element A: Measure Clinical Quality Performance</u>	●	
196		1. At least two immunization measures.	●	
197		2. At least two other preventive care measures.	●	
198		3. At least three chronic or acute care measures.	●	
199		4. Performance data stratified for vulnerable populations (to assess disparities in care). (NEW CRITICAL)	●	We recommend doing a data analysis at the practice of what is achievable. There may be technical challenges, but this will be assessed during our initial on-site meeting.
201		<u>–Element B: Measure Resource use and Care Coordination</u>	●	We do not see any issues with Standard 6 Element B.
202		1. At least two measures related to care coordination.	●	
203		2. At least two utilization measures affecting health care costs.	●	
205		<u>–Element C: Measure Patient/Family Experience (NEW MUST-PASS)</u>	●	We do not see any issues with Standard 6 Element C.
206		1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:	●	
207	•Access.	●		
208	•Communication.	●		

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209		•Coordination.	●	
210		•Whole person care/self-management support.	●	
211		2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool.	●	
212		3. The practice obtains feedback on experiences of vulnerable patient groups. (NEW CRITICAL)	●	
213		4. The practice obtains feedback from patients/families through qualitative means.	●	
214		<p>–Area of Emphasis: (Standard 6: Element C)</p> <p><i>–Implementation of Patient-Family Advisory Panels at the practice for quarterly feedback and continuous quality improvement. Patient-Family Advisory Panels will help to inform the practice team on how to provide better patient-centered care and improve patient satisfaction.</i></p>	●	See comment in line 59.
216		<u>–Element D: Measure Patient/Family Experience (MUST-PASS)</u>	●	We do not see any issues with Standard 6 Element D.
217		1. Set goals and analyze at least three clinical quality measures from Element A.	●	
218		2. Act to improve at least three clinical quality measures from Element A.	●	
219		3. Set goals and analyze at least one measure from Element B.	●	
220		4. Act to improve at least one measure from Element B.	●	
221		5. Set goals and analyze at least one patient experience measure from Element C.	●	
222		6. Act to improve at least one patient experience measure from Element C.	●	
223		7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.	●	

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224		<p><i>–Area of Emphasis: (Standard 6: Element D)</i> <i>–Set goals and address at least one identified disparity in care/service for identified vulnerable population</i></p>	●	See comment in line 199.
226		<p><u>–Element E: Demonstrate Continuous Quality Improvement</u></p>	●	We do not see any issues with Standard 6 Element E.
227		1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.	●	
228		2. Achieving improved performance on at least two clinical quality measures.	●	
229		3. Achieving improved performance on one utilization or care coordination measure.	●	
230		4. Achieving improved performance on at least one patient experience measure.	●	
232		<p><u>–Element F: Report Performance</u></p>	●	We do not see any issues with Standard 6 Element F.
233		1. Individual clinician performance results with the practice.	●	
234		2. Practice-level performance results with the practice.	●	
235		3. Individual clinician or practice-level performance results publicly.	●	
236		4. Individual clinician or practice-level performance results with patients.	●	
238		<p><u>–Element G: Use Certified EHR Technology</u></p>	●	We do not see any issues with Standard 6 Element G.
239		1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.	●	
240		2. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies.	●	

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241		3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.	●	
242		4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.	●	
243		5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.	●	
244		6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for meaningful use.	●	
245		7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.	●	
246		8. The practice has access to a health information exchange.	●	
247		9. The practice has bi-directional exchange with a health information exchange.	●	
248		10. The practice generates lists of patients, and based on their preferred method of communication, proactively reminds more than 10 percent of patients/families/caregivers about needed preventive/follow-up care.	●	
250		<p><i>–Area of Emphasis: CT AMH Specific (not in NCQA 2014)</i> <i>–Track primary care team satisfaction pre- and post- AMH program</i></p>	●	We do not see any issues with having this as an elective Area of Emphasis.