



National Standards for Systems of Care for Children and Youth with Special Health Care Needs: Crosswalk to National Committee for Quality Assurance Primary Care Medical Home Recognition Standards

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States are in the midst of rapid transformation of their health care delivery systems. In an effort to reduce health care costs and improve the delivery and quality of care, many states have shifted Medicaid enrollees – including children and adults with chronic and complex health care needs – into managed care. As of June 2017, nearly all states (48) contract with managed care organizations to provide services to Medicaid beneficiaries and of these states, all are enrolling at least some population of children and youth with special health care needs (CYSHCN) into managed care, either voluntarily or mandatorily.¹ As these reforms to Medicaid managed care systems are designed and implemented, states have an important opportunity to ensure that the unique needs of CYSHCN are considered.

These dramatic changes in state managed care delivery systems have significant implications for CYSHCN, particularly those with complex health care needs. CYSHCN and their families typically receive services and supports from multiple systems – health care, public health, education, mental health, social services, respite, and more. Within any one of these systems, children may be served by multiple providers and community-based systems. This need for multiple services and supports presents challenges for developing comprehensive systems of care among health care and other child-serving systems. In addition to being served by multiple providers, CYSHCN have unique needs that require a different level of care. Approximately 19 percent of all US children ages birth to 18 years (over 14 million children) have a chronic and/or complex health care need (e.g., asthma, diabetes, spina bifida) requiring health care services and supports beyond what children require normally.² Families of CYSHCN report unmet needs particularly for specialty care, dental and mental health care services, and care coordination. CYSHCN who are black or Hispanic, live in households with limited English proficiency, or are low-income have higher unmet health care needs and are less likely to have access to a medical home as compared to their counterparts.³

About the National Standards for CYSHCN

The [National Standards for Systems of Care for Children and Youth and Special Health Care Needs](#)⁴ outline the core components of an effective system of care for this population of children. The National Standards are intended for use or adaptation by a wide range of stakeholders at the national, state, and local levels. The standards and related core domain areas were derived from a comprehensive review of the literature, early guidance during the project from more than 30 key informants, case studies of standards currently in use within

¹ *How States are Serving Children and Youth with Special Health Care Needs in Medicaid Managed Care: A 50-State Review*. Washington, DC: National Academy for State Health Policy. (*in-process*).

² U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health, 2009-2010. Rockville, MD: US Department of Health and Human Services accessed January 6, 2016, www.childhealthdata.org.

³ Kuo DZ, Goudie A, Cohen E, Houtrow A, Agrawal R, Carle AC, Wells N. Inequities in Health Care Needs for Children with Medical Complexity. *Health Affairs*. 2014; 33(12): 1-18.

⁴ *National Standards for Systems of Care for Children and Youth with Special Health Care Needs. Version 2.0*. Washington, DC: Association of Maternal & Child Health Programs and the National Academy for State Health Policy. June 2017.

selected sites, and guidance and consensus from a national work group comprised of national and state leaders representing state Title V CYSHCN programs, health plans, state Medicaid and CHIP agencies, pediatric providers, children’s hospitals, insurers, health services researchers, families/consumers, and others. The National Committee for Quality Assurance (NCQA) standards on medical home were among key documents consulted to ensure that the National Standards aligned with those required for use by managed care organizations and practice certification.

About this Crosswalk Tool

Health plans seek NCQA accreditation to demonstrate a commitment to quality. More than 30 state Medicaid programs⁵ either use or require NCQA health plan accreditation within their programs. This crosswalk tool was developed in response to requests from health plan representatives, state Medicaid agencies, and other state health policymakers involved in providing programs, services, and coverage to CYSHCN in order to better incorporate the unique needs of children with special health care needs into Medicaid managed care. The crosswalk can also help states and health plans to best understand how medical home accreditation requirements for health plans align with National Standards.

This crosswalk features the NCQA Primary Care Medical Home Recognition (PCMH)⁶ program. This recognition program is used for primary-care practices that are interested in becoming a medical home. A practice that makes the decision to be a medical home can provide better coordinated care to patients at lower costs, higher quality, and with better patient experiences and outcomes.

How this Crosswalk Tool Can Help State Medicaid Agencies and Managed Care Organizations

State Medicaid agencies contract with health plans to provide health care services to Medicaid enrollees. Some states are using the National Standards in these contracts to improve the quality of care provided to CYSHCN. As part of health system transformation efforts, several states are requiring managed care plans to have their provider practices become NCQA-certified in the area of medical homes.⁷ In states that do not require NCQA certification, managed care plans may still be interested in NCQA requirements as a way to improve quality.

As states undertake this important work of health system transformation, it is essential that the unique needs of children with chronic and complex health care conditions be considered. Several states and health plans have compared the National Standards for CYSHCN with the NCQA standards to understand how closely they align and identify areas where they may want to expand upon the NCQA standards in order to align managed care contracts with the National Standards. For example, a state or health plan that requires or encourages NCQA PCMH recognition for providers might want to include additional provisions within their contracts to ensure that the needs of CYSHCN are being met. This comparison of standards has proven to be a helpful way to incorporate the needs of CYSHCN into the larger work of setting standards. While understanding that NCQA standards are very specific and achieving NCQA accreditation is contingent upon meeting specific requirements, this tool can also help any organization or state who is interested in promoting quality of care for CYSHCN in a way that aligns with NCQA standards.

⁵ National Committee for Quality Assurance. Map of States using NCQA Accreditation in commercial or Medicaid managed care oversight. 2016. Available at: <http://www.ncqa.org/public-policy/working-with-states>

⁶ National Committee for Quality Assurance. *Standards and Guidelines for NCQA’s Patient-Centered Medical Home (PCMH) 2017*. Available at: <http://www.ncqa.org>.

⁷ Takach, M. Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results. *Health Affairs*. 2011; 30(7): 1325-1334. <http://content.healthaffairs.org/content/30/7/1325.full>

How to Read this Crosswalk

The crosswalk tool indicates which National Standards for CYSHCN are applicable to a particular NCQA standard element. All National Standards for CYSHCN were found to align with NCQA standards except for 'Eligibility and Enrollment in Health Coverage', so this National Standard is not included in the crosswalk. When a NCQA standard is not listed, there were no National Standards in alignment. Within all tables, the National Standards for Systems of Care for CYSHCN (NS) are listed along the left-hand side, while the NCQA standards are listed across the top row of the crosswalk. Where there is a relevant National Standard for CYSHCN that corresponds to an element of an NCQA standard is indicated by a checkmark, a summary of the relevant National Standard is listed below the table. The information contained in this crosswalk is a summary of the National Standards and the NCQA standards, and is intended to be used alongside these larger resources. For full language of standards, please see footnotes.

For More Information About the National Standards

For full language of National Standards please see:

- [Standards for Systems of Care for Children and Youth with Special Health Care Needs, Version 2.0](#)
- [National Standards website](#)
- [Developing Structure and Process Standards for Systems of Care Serving Children and Youth with Special Health Care Needs: A White Paper from the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project](#)

For more information on NCQA Standards, please visit the [NCQA website](#).

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Table 1. Summary of Crosswalk

National Standards for Systems of Care for CYSHCN	NCQA Standards					
	Team-Based Care and Practice Organization (TC)	Knowing & Managing Your Patients (KM)	Patient-Centered Access & Continuity (AC)	Care Management & Support (CM)	Care Coordination & Care Transitions (CC)	Performance Measurement & Quality Improvement (QI)
Foundational Standards	✓	✓		✓	✓	
Identification, Screening, Assessment, and Referral		✓		✓	✓	
Access to Care		✓	✓			
Medical Home	✓	✓	✓	✓	✓	
Community Based Services and Supports		✓			✓	
Health Information Technology	✓		✓		✓	
Transition to Adulthood					✓	
Quality Assurance and Improvement	✓	✓			✓	✓

Appendix A. NCQA Standard 1: Team-Based Care and Practice Organization (TC)

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

NCQA Standards									
National Standards for Systems of Care for CYSHCN	NCQA TC 01: PCMH Transformation Leads	NCQA TC 02: Structure and Staff Responsibilities	NCQA TC 03: External PCMH Collaborations	NCQA TC 04: Patient/Family/Caregiver Involvement in Governance	NCQA TC 05: Certified EHR System	NCQA TC 06: Individual Patient Care Meetings/Communication	NCQA TC 07: Staff Involvement in Quality Improvement	NCQA TC 08: Behavioral Health Care Manager	NCQA TC 09: Medical Home Information
Foundational Standards				✓					✓
Identification, Screening, Assessment, and Referral									
Access to Care									
Medical Home	✓	✓	✓			✓		✓	
Community Based Services and Support									
Health Information Technology			✓		✓				
Transition to Adulthood									
Quality Assurance and Improvement				✓			✓		

NCQA TC 01—PCMH Transformation Leads: *Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.*

- **NS Medical Home 2.** The medical home provides team-based care that is led by a primary care clinician and/or pediatric subspecialist and in which the family is a core member.

NCQA TC 02—Structure and Staff Responsibilities: *Defines practice’s organizational structure and staff responsibilities/skills to support key PCMH functions.*

- **NS Medical Home 2.** The medical home provides team-based care that is led by a primary care clinician and/or pediatric subspecialist and in which the family is a core member
- **NS Medical Home—Care Coordination 2.** Care coordinators: Serve as a member of the medical home team.

NCQA TC 03—External PCMH Collaborations: *The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).*

- **NS Medical Home—Pediatric Specialty Care 2.** System encourages shared management of CYSHCN between pediatric primary care and specialty providers through payment models or policies that promote integration among systems.
- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.
- **NS Health Information Technology 4.** Documented processes exist for exchanging health information across care settings, including an agreement about exchanging information, the types of information to be exchanged, time frames for exchanging information, and to what extent referrals are made electronically.

NCQA TC 04—Patient/Family/Caregiver Involvement in Governance: *Patients/families/caregivers are involved in the practice’s governance structure or on stakeholder committees.*

- **NS Foundational Standard 1.** Children and families of CYSHCN are active, core partners in decision making in all levels of care.
- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place in which families of CYSHCN are represented on the primary care provider QI teams and health plan QI teams.

NCQA TC 05—Certified EHR System: *The practice uses a certified electronic health record technology system (CEHRT).*

- **NS Health Information Technology 1.** Electronic health information should be accessible, retrievable, and available across systems.
- **NS Health Information Technology 3.** Families have easy access to their electronic health information.

NCQA TC 06—Individual Patient Care Meetings/Communication: *Has regular patient care team meetings or a structured communication process focused on individual patient care.*

- **NS Medical Home—Medical Home Management 11.** The medical home performs care tracking, including sending of proactive reminders to families and clinicians of services needed, via a registry or other mechanism.

NCQA TC 07: Staff Involvement in Quality Improvement: *Involves care team staff in the practice’s performance evaluation and quality improvement activities.*

- **NS Quality Assurance and Improvement 3.** The utilization review and appeals processes for CYSHCN includes members of a child’s integrated care team when requested by the family.

NCQA TC 08: Behavioral Health Care Manager: *Has at least one care manager qualified to identify and coordinate behavioral health needs.*

- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators use bio-psychosocial assessments to help families articulate goals and priorities for care which take into account social determinants that impact the health of their child

NCQA TC 09: Medical Home Information: *Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.*

- **NS Foundational Standard 2.** All services and supports for CYSHCN are implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner to best serve CYSHCN and their families.

Appendix B. NCQA Standard 2: Knowing and Managing Your Patients (KM)—Part 1

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

NCQA Standards												
National Standards for Systems of Care for CYSHCN	NCQA KM 01: Problem Lists	NCQA KM 02: Comprehensive Health Assessment	NCQA KM 03: Depression Screening	NCQA KM 04: Behavioral Health Screenings	NCQA KM 05: Oral Health Assessment Services	NCQA KM 06: Predominant Conditions & Concerns	NCQA KM 07: Social Determinants of Health	NCQA KM 08: Patient Materials	NCQA KM 09: Diversity	NCQA KM 10: Language	NCQA KM 11: Population needs	NCQA KM 12: Proactive Reminders
Foundational Standards								✓			✓	
Identification, Screening, Assessment, and Referral			✓	✓	✓							✓
Access to Care										✓		
Medical Home	✓	✓	✓	✓			✓	✓	✓			✓
Community Based Services and Support										✓		
Health Information Technology												
Transition to Adulthood												
Quality Assurance and Improvement						✓	✓		✓	✓		

NCQA KM 01—Problem Lists: *Documents an up-to-date problem list for each patient with current and active diagnoses.*

- **NS Medical Home—Medical Home Management 4.** Pre-visit assessments are completed by the medical home with the family to ensure the medical home team has comprehensive data on the child/family and provides care in an appropriate manner.
- **NS Medical Home—Medical Home Management 7.** The medical home develops, maintains, and updates a comprehensive, integrated plan of care that includes patient/family identified goals.
- **NS Medical Home—Medical Home Management 8.** The medical home serving CYSHCN has a process for keeping an updated record of and managing medications.
- **NS Medical Home—Care Coordination 3.** A plan of care is jointly developed, shared, and implemented among the CYSHCN and their family, primary care provider and/or specialists serving as the principal coordinating physician and members of the health care team.

NCQA KM 02—Comprehensive Health Assessment: *Comprehensive health assessment includes (all items required): Medical history of patient and family; Mental health/substance use history of patient and family; Family/social/cultural characteristics; Communication needs; Behaviors affecting health; Social functioning; Social determinants of health; Developmental screening using a standardized tool; and Advance care planning.*

- **NS Medical Home—Medical Home Management 3.** The medical home performs comprehensive health assessments.
- **NS Medical Home—Medical Home Management 4.** Pre-visit assessments are completed by the medical home with the family to ensure the medical home team has comprehensive data on the child/family and provides care in an appropriate manner.
- **NS Medical Home—Medical Home Management 5.** Accommodations for special needs, such as provision of home visits versus office visits are made available by the medical home.
- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators use bio-psychosocial assessments to help families articulate goals and priorities for care which take into account social determinants that impact the health of their child.

NCQA KM 03—Depression Screening: *Conducts depression screenings for adults and adolescents using a standardized tool.*

- **NS Identification, Screening, Assessment, and Referral 3.** CYSHCN receive periodic, developmentally appropriate, and recommended comprehensive screenings according to the Bright Futures guidelines.
- **NS Identification, Screening, Assessment, and Referral 4.** Screening results are documented and coordinated with the medical home.
- **NS Medical Home—Medical Home Management 3.** The medical home provider performs comprehensive health assessments.

NCQA KM 04—Behavioral Health Screenings: *Conducts behavioral health screenings and/or assessments using a standardized tool (e.g. pediatric behavioral health screening).*

- **NS Identification, Screening, Assessment, and Referral 3.** CYSHCN receive periodic, developmentally appropriate, and recommended comprehensive screenings according to the Bright Futures guidelines.
- **NS Identification, Screening, Assessment, and Referral 4.** Screening results are documented and coordinated with the medical home.
- **NS Medical Home—Medical Home Management 3.** The medical home provider performs comprehensive health assessments.

NCQA KM 05—Oral Health Assessment and Services: *Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.*

- **NS Identification, Screening, Assessment, and Referral 3.** CYSHCN receive periodic, developmentally appropriate, and recommended comprehensive screenings according to the Bright Futures guidelines.

NCQA KM 06—Predominant Conditions and Concerns: *Identifies the predominant conditions and health concerns of the patient population.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing QA and QI process in place.
- **NS Quality Assurance and Improvement 2.** Child medical record reviews include a representative sample of CYSHCN so that the experiences of this population are reflected in QA and QI activities.

NCQA KM 07—Social Determinants of Health: *Understands social determinants of health for patients, monitors at the population level, and implements care interventions based on these data.*

- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators use bio-psychosocial assessments to help families articulate goals and priorities for care which take into account social determinants that impact the health of their child.
- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing QA and QI process in place, including assessment of out of pocket expenses, lost work burden and other sources of stress on families, and the assessment of child outcomes, including measures of health and functional status.

NCQA KM 08—Patient Materials: *Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.*

- **NS Foundational Standard 2.** All services and supports for CYSHCN are implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner to best serve CYSHCN and their families.
- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators provide appropriate resources to match the health literacy level, primary language, and culture of CYSHCN and their family.

NCQA KM 09—Diversity: *Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.*

- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators provide appropriate resources to match the health literacy level, primary language, and culture of CYSHCN and their family.
- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing QA and QI process in place, including conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups).

NCQA KM 10—Language: *Assesses the language needs of its population.*

- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators provide appropriate resources to match the health literacy level, primary language, and culture of CYSHCN and their family.
- **NS Community-Based Services and Supports—Palliative and Hospice Care 2.** Palliative and hospice care utilizes family-centered models of care that respect the CYSHCN and their family's preferences, values, and cultural beliefs, and provide family access to psychosocial screening and referrals to needed supports and services.
- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing QA and QI process in place, including conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups).

NCQA KM 11—Population Needs: *Identifies and addresses population-level needs based on the diversity of the practice and the community.*

- **NS Foundational Standard 2.** All services and supports for CYSHCN are implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner to best serve CYSHCN and their families.

NCQA KM 12— Proactive Outreach: *Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers, about needed services.*

- **NS Identification, Screening, Assessment, and Referral 10.** Protocols and documentation methods are in place for the child's medical home to follow-up with the child and family to ensure referred services were accessed and to provide any assistance in accessing needed care, regardless of the original entity conducting a screening and referral.
- **NS Medical Home—Medical Home Management 11.** The medical home performs care tracking, including sending of proactive reminders to families and clinicians of services needed, via a registry or other mechanism.

Appendix B. NCQA Standard 2: Knowing and Managing Your Patients (KM)—Part 2

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

National Standards for Systems of Care for CYSHCN	NCQA Standards											
	NCQA KM 13: Excellence in Performance	NCQA KM 14: Medication Reconciliation	NCQA KM 15: Medication Lists	NCQA 16: New Prescription Education	NCQA KM 20: Clinical Decision Support	NCQA KM 21: Community Resource Needs	NCQA KM 22: Access to Education Resources	NCQA KM 23: Oral Health Education	NCQA KM 24: Shared Decision-Making Aids	NCQA KM 25: School Intervention Agency Engagement	NCQA KM 26: Community Resource List	NCQA KM 28: Case Conferences
Foundational Standards	✓				✓				✓			
Identification, Screening, Assessment, and Referral					✓							
Access to Care												
Medical Home		✓	✓	✓	✓		✓	✓	✓			✓
Community Based Services and Support						✓	✓		✓	✓	✓	
Health Information Technology												
Transition to Adulthood												
Quality Assurance and Improvement												

NCQA KM 13—Excellence in Performance: *Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines.*

- **NS Foundational Standard 4.** All care provided to CYSHCN and their families is evidence-based where possible, and evidence-informed and/or based on promising practices where evidence-based approaches do not exist.

NCQA KM 14—Medication Reconciliation: *Reviews and reconciles medications for more than 80 percent of patients received from care transitions.*

- **NS Medical Home—Medical Home Management 8.** The medical home has a process for keeping an updated record of and managing medications.
- **NS Medical Home—Medical Home Management 10.** The medical home conducts effective transitions of care between primary and specialty services, facilities, and providers and institutional settings to ensure preference for health services and sharing of information across systems.

NCQA KM 15—Medication Lists: *Maintains an up-to-date list of medications for more than 80 percent of patients.*

- **NS Medical Home—Medical Home Management 8.** The medical home serving CYSHCN has a process for keeping an updated record of and managing medications.

NCQA KM 16—New Prescription Education: *Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.*

- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators provide appropriate resources to match the health literacy level, primary language, and culture of CYSHCN and their family.

NCQA KM 20—Clinical Decision Support: *Implements clinical decision support following evidence-based guidelines for care of a mental health condition or well child care.*

- **NS Foundational Standard 4.** All care provided to CYSHCN and their families is evidence-based where possible, and evidence-informed and/or based on promising practices where evidence-based approaches do not exist.
- **NS Identification, Screening, Assessment, and Referral 3.** CYSHCN receive periodic, developmentally appropriate, and recommended comprehensive screenings according to the Bright Futures guidelines.
- **NS Medical Home—Pediatric Preventive and Primary Care 2.** CYSHCN receive recommended immunizations according to the Advisory Committee on Immunization Practices (ACIP).

NCQA KM 21—Community Resource Needs: *Uses information on the population served by the practice to prioritize needed community resources.*

- **NS Community-Based Services and Supports 1.** CYSHCN are provided access to comprehensive home and community-based supports. Agreements are in place between the health systems and community agencies including family organizations, public health, education, Early Intervention (Part C), Special Education, child welfare, mental health, and home health care organizations.

NCQA KM 22—Access to Educational Resources: *Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.*

- **NS Medical Home—Medical Home Management 6.** The medical home conducts activities to support CYSHCN and their families in self-management of the child's health and health care.
- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators provide appropriate resources to match the health literacy level, primary language, and culture of CYSHCN and their family.
- **NS Community-Based Services and Supports 1.** CYSHCN are provided access to comprehensive home and community-based supports. Agreements are in place between the health systems and community agencies including family organizations, public health, education, Early Intervention (Part C), Special Education, child welfare, mental health, and home health care organizations, and are structured to promote family support through linking families to family organizations and other services and supports.

NCQA KM 23—Oral Health Education: *Provides oral health education resources to patients.*

- **NS Medical Home 1.** All CYSHCN have a medical home capable of providing or coordinating services to meet the child's medical, dental, and social-emotional needs.

NCQA KM 24—Shared Decision-Making Aids: *Adopts shared decision-making aids for preference-sensitive conditions.*

- **NS Foundational Standard 1.** Children and families of CYSHCN are active, core partners in decision making in all levels of care.
- **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators provide appropriate resources to match the health literacy level, primary language, and culture of CYSHCN and their family.
- **NS Medical Home—Care Coordination 4.** Family strengths are respected in the delivery of care, extended family members are included in decision making according to the family's wishes and family-driven goals are incorporated into the plan of care.
- **NS Community-Based Services and Supports—Palliative and Hospice Care 2.** Palliative and hospice care utilizes family-centered models of care that respect the CYSHCN and their family's preferences, values, and cultural beliefs, and provide family access to psychosocial screening and referrals to needed supports and services.

NCQA KM 25—School/Intervention Agency Engagement: *Engages with schools or intervention agencies in the community.*

- **NS Community-Based Services and Supports 1.** CYSHCN are provided access to comprehensive home and community-based supports. Agreements are in place between the health systems and community agencies including family organizations, public health, education, Early Intervention (Part C), Special Education, child welfare, mental health, and home health care organizations.

NCQA KM 26: Community Resource List: *Routinely maintains a current community resource list based on the needs identified.*

- **NS Community-Based Services and Supports 1.** CYSHCN are provided access to comprehensive home and community-based supports. Agreements are in place between the health systems and community agencies including family organizations, public health, education, Early Intervention (Part C), Special Education, child welfare, mental health, and home health care organizations to promote collaboration between community-based organizations and agencies, providers, health care systems, and families, and specify responsibilities across the various providers, and community-based agencies.

NCQA KM 28: Case Conferences: *Has regular “case conferences” involving parties outside the practice team (e.g., community supports, specialists).*

- **NS Medical Home—Medical Home Management 9.** The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.
 - **NS Medical Home—Medical Home Management 10.** The medical home conducts effective transitions of care between primary and specialty services, facilities, and providers and institutional settings to ensure preference for health services and sharing of information across systems.
 - **NS Medical Home—Care Coordination 1.** All CYSHCN have access to patient and family-centered care coordination that integrates physical, oral, mental health and community-based services.
 - **NS Medical Home—Care Coordination 2.** To provide optimal coordination and integration of services that are needed by the child and family, care coordinators have ongoing relationships with families, medical care providers, and other partners in care.
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Appendix C. NCQA Standard 3: Patient-Centered Access and Continuity (AC)

The PCMH model expects continuity of care. Patients/families/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 practice considers the needs and preferences of the patient population when establishing and updating standards for access.

NCQA Standards									
National Standards for Systems of Care for CYSHCN	NCQA AC 01: Access Needs & Preferences	NCQA AC 02: Same-day Appointments	NCQA AC 03: Appointment Outside Business Hours	NCQA AC 04: Timely Clinical Advice by Telephone	NCQA AC 05: Clinical Advice Documentation	NCQA AC 06: Alternative Appointments	NCQA AC 07: Electronic Patient Records	NCQA AC 10: Personal Clinician Selection	NCQA AC 12: Continuity of Medical Record Information
Foundational Standards									
Identification, Screening, Assessment, and Referral									
Access to Care	✓					✓		✓	
Medical Home	✓	✓	✓	✓				✓	✓
Community Based Services and Support									
Health Information Technology					✓		✓		✓
Transition to Adulthood									
Quality Assurance and Improvement									

NCQA AC 01—Access Needs and Preferences: *Assesses the access needs and preferences of the patient population.*

- **NS Access to Care 1.** The system has the capacity and processes in place to ensure CYSHCN geographic and timely access to primary and specialty services.
- **NS Access to Care 3.** Transportation assistance is provided to families with difficulties accessing needed medical services.
- **NS Medical Home—Medical Home Management 2.** The medical home utilizes scheduling systems that recognize the additional time involved in caring for CYSHCN.
- **NS Medical Home—Medical Home Management 5.** Accommodations for special needs, such as provision of home visits versus office visits are made available by the medical home.

NCQA AC 02—Same-Day Appointments: *Provides same-day appointments for routine and urgent care to meet identified patient needs.*

- **NS Access to Care 2.** Reasonable access requirements and wait times are in place for routine, episodic, urgent, and emergent physical, oral, mental health and rehabilitative services. Same day appointments are made available for urgent care services.

NCQA AC 03—Appointments Outside Business Hours: *Provides routine and urgent appointments outside regular business hours to meet identified patient needs.*

- **NS Medical Home—Medical Home Management 1.** The medical home provides access to health care services 24 hours, seven days a week.

NCQA AC 04—Timely Clinical Advice by Telephone: *Provides timely clinical advice by telephone.*

- **NS Medical Home—Medical Home Management 1.** The medical home provides access to health care services 24 hours, seven days a week.

NCQA AC 05—Clinical Advice Documentation: *Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.*

- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.

NCQA AC 06—Alternative Appointments: *Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.*

- **NS Access to Care 4.** Satellite programs, electronic communications, and telemedicine are used to enhance access to specialty care and regional pediatric centers of excellence, where available, and other multidisciplinary teams of pediatric specialty providers.

NCQA AC 07—Electronic Patient Requests: *Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.*

- **NS Health Information Technology 1.** Electronic health information should be accessible, retrievable, and available across systems and meet meaningful use requirements.
- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.

NCQA AC 10—Personal Clinical Selection: *Helps patients/families/ caregivers select or change a personal clinician.*

- **NS Access to Care 5.** Written policies and procedures are in place that describe how CYSHCN choose and/or are assigned to a PCP and how they may change their PCP.
- **NS Access to Care 6.** Pediatric specialists who have a demonstrated clinical relationship as the clinical coordinator of all care for the child are able to serve as a primary care provider (PCP).
- **NS Medical Home 2.** The medical home provides team-based care that is led by a primary care clinician and/or pediatric subspecialist and in which the family is a core member
- **NS Medical Home—Care Coordination 4.** Family strengths are respected in the delivery of care, extended family members are included in decision making according to the family's wishes and family-driven goals are incorporated into the plan of care.

NCQA AC 12—Continuity of Medical Record Information: *Provides continuity of medical record information for care and advice when the office is closed.*

- **NS Medical Home—Medical Home Management 9.** The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.
- **NS Health Information Technology 1.** Electronic health information should be accessible, retrievable, and available across systems and meet meaningful use requirements.
- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.
- **NS Health Information Technology 4.** Documented processes exist for exchanging health information across care settings.

Appendix D. NCQA Standard 4: Care Management and Support (CM)

The practice 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.

NCQA Standards								
National Standards for Systems of Care for CYSHCN	NCQA CM 01: Identifying Patients Care Management	NCQA CM 02: Monitoring Patients for Care Management	NCQA CM 04: Person-Centered Care Plans	NCQA CM 05: Written Care Plans	NCQA CM 06: Patient Preferences & Goals	NCQA CM 07: Patient Barriers to Goals	NCQA CM 08: Self-Management Plans	NCQA CM 09: Care Plan Integration
Foundational Standards					✓	✓		
Identification, Screening, Assessment, and Referral	✓							
Access to Care								
Medical Home	✓	✓	✓	✓	✓	✓	✓	✓
Community Based Services and Support								
Health Information Technology								
Transition to Adulthood								
Quality Assurance and Improvement								

NCQA CM 01—Identifying Patients for Care Management: Considers behavioral health conditions; high cost/high utilization; poorly controlled or complex conditions; social determinants of health; and referrals by outside organizations when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria).

- **NS Identification, Screening, Assessment, and Referral 2.** Upon enrollment and transfer between insurance coverage, a mechanism for identifying CYSHCN, is in place.
- **NS Medical Home—Medical Home Management 4.** Pre-visit assessments are completed by the medical home with the family to ensure the medical home team has comprehensive data on the child/family and provides care in an appropriate manner.
- **NS Medical Home—Medical Home Management 7.** The medical home develops, maintains, and updates a comprehensive, integrated plan of care that includes patient/family-identified goals.
- **NS Medical Home—Care Coordination 1.** All CYSHCN have access to patient and family-centered care coordination that integrates physical, oral, mental health and community-based services.

NCQA CM 02—Monitoring Patients for Care Management: *Monitors the percentage of the total patient population identified through its process and criteria.*

- **NS Medical Home—Care Coordination 1.** All CYSHCN have access to patient and family-centered care coordination that integrates physical, oral, mental health and community-based services.

NCQA CM 04—Person-Centered Care Plans: *Establishes a person-centered care plan for patients identified for care management.*

- **NS Medical Home—Care Coordination 3.** A plan of care is jointly developed, shared, and implemented among the CYSHCN and their family, PCP, and members of the health care team.
- **NS Medical Home—Care Coordination 4.** Family strengths are respected in the delivery of care, extended family members are included in decision making according to the family's wishes, and family-driven goals are incorporated into the plan of care.

NCQA CM 05—Written Care Plans: *Provides a written care plan to the patient/family/caregiver for patients identified for care management.*

- **NS Medical Home—Care Coordination 3.** A plan of care is jointly developed, shared, and implemented among the CYSHCN and their family, primary care provider and/or the specialist serving as the principal coordinating physician and members of the health care team.

NCQA CM 06: Patient Preferences and Goals: *Documents patient preference and functional/lifestyle goals in individual care plans.*

- **NS Foundation Standard 1.** Children and families of CYSHCN are active, core partners in decision making in all levels of care.
- **NS Medical Home—Care Coordination 2.** Care coordinators use biopsychosocial assessments to help families articulate goals and priorities for care which take into account social determinants that impact the health of their child.
- **NS Medical Home—Care Coordination 4.** Family strengths are respected in the delivery of care, extended family members are included in decision making according to the family's wishes and family-driven goals are incorporated into the plan of care.

NCQA CM 07—Patient Barriers to Goals: *Identifies and discusses potential barriers to meeting goals in individual care plans.*

- **NS Foundation Standard 1.** Children and families of CYSHCN are active, core partners in decision making in all levels of care.
- **NS Medical Home—Care Coordination 2.** Care coordinators: have ongoing relationships with families, medical care providers, and other partners in care, and use biopsychosocial assessments to help families articulate goals and priorities for care which take into account social determinants that impact the health of their child.

NCQA CM 08—Self-Management Plans: *Includes a self-management plan in individual care plans.*

- **NS Medical Home—Medical Home Management 6.** The medical home conducts activities to support CYSHCN and their families in self-management of the child's health and health care.

NCQA CM 09—Care Plan Integration: Care plan is integrated and accessible across settings of care.

- **NS Medical Home—Care Coordination 3.** A plan of care is jointly developed, shared, and implemented among the CYSHCN and their family, primary care provider and/or the specialist serving as the principal coordinating physician and members of the health care team.
- **NS Medical Home—Pediatric Specialty Care 2.** The system encourages shared management of CYSHCN between pediatric primary care and specialty providers through payment models or other policies that promote improved integration among multiple systems.

Appendix E. NCQA Standard 5: Care Coordination and Care Transitions (CC)—Part 1

The practice 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.

NCQA Standards								
National Standards for Systems of Care for CYSHCN	NCQA CC 02: Newborn Screenings	NCQA CC 03: Appropriate Use for Labs and Imaging	NCQA CC 04: Referral Management	NCQA CC 08: Specialist Referral Expectations	NCQA CC 09: Behavioral Health Referral Expectations	NCQA CC 10: Behavioral Health Integration	NCQA CC 11: Referral Monitoring	NCQA CC 12: Co-Management Arrangements
Foundational Standards		✓						
Identification, Screening, Assessment, and Referral	✓		✓					
Access to Care								
Medical Home			✓	✓	✓	✓		✓
Community Based Services and Support				✓				
Health Information Technology							✓	
Transition to Adulthood								
Quality Assurance and Improvement								

NCQA CC 02—Newborn Screenings: Follows up with the inpatient facility about newborn hearing and blood-spot screening.

- **NS Identification, Screening, Assessment, and Referral 4.** Screening results are documented and coordinated with the medical home.
- **NS Identification, Screening, Assessment, and Referral 5.** State newborn screening information is delivered to providers and parents in a timely fashion and arrangements for necessary follow-up services are documented.
- **NS Identification, Screening, Assessment, and Referral 6.** The child's health plan and medical home have a documented plan and process to demonstrate follow-up with a hospital or state health department when newborn screening results are not received.

NCQA CC 03—Appropriate Use for Labs and Imaging: *Uses clinical protocols to determine when imaging and lab tests are necessary.*

- **NS Foundation Standard 4:** All care provided to CYSHCN and their families is evidence-based where possible, and evidence-informed and/or based on promising practices where evidence-based approaches do not exist.

NCQA CC 04: Referral Management: The practice systematically manages referrals by: giving the consultant or specialist the clinical question, the required timing, and the type of referral; giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan; and tracking referrals until the consultant or specialist's report is available.

- **NS Identification, Screening, Assessment, and Referral 9.** Following a screening and assessment, CYSHCN are referred to needed services including pediatric specialists, therapies, and other service systems.
- **NS Identification, Screening, Assessment, and Referral 10.** Protocols and documentation methods are in place for the child's medical home to follow-up with the child and family to ensure referred services were accessed and to provide any assistance in accessing needed care, regardless of the original entity conducting a screening and referral.
- **NS Medical Home—Medical Home Management 9.** The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.
- **NS Medical Home—Medical Home Management 11.** The medical home performs care tracking, including sending of proactive reminders to families and clinicians of services needed, via a registry or other mechanism.
- **NS Medical Home—Care Coordination 2.** Care coordinators have ongoing relationships with families, medical care providers, and other partners in care.

NCQA CC 08—Specialist Referral Expectations: *Works with nonbehavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.*

- **NS Medical Home—Medical Home Management 9.** The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.
- **NS Community-Based Services and Supports 1.** Agreements are in place between the health systems and community agencies including family organizations, public health, education, Early Intervention (Part C), Special Education, child welfare, mental health, and home health care organizations and are structured to establish systems for timely communications and appropriate data sharing and to specify responsibilities across the various providers and community-based agencies.

NCQA CC 09—Behavioral Health Referral Expectations: *Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.*

- **NS Medical Home—Medical Home Management 9.** The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.
- **NS Medical Home—Pediatric Specialty Care 1.** Comprehensive specialty services, including behavioral health services, acute services in a 24-hour clinical setting, intermediate services, and outpatient services and community support services are made available by specialty providers when needed.

- **NS Medical Home—Pediatric Specialty Care 2.** The system encourages shared management of CYSHCN between pediatric primary care and specialty providers through payment models or other policies that promote improved integration among multiple systems.

NCQA CC 10—Behavioral Health Integration: *Integrates behavioral healthcare providers into the care delivery system of the practice site.*

- **NS Medical Home 1.** All CYSHCN have a medical home capable of providing or coordinating services to meet the child's medical, dental and social-emotional needs.
- **NS Medical Home—Care Coordination 1.** All CYSHCN have access to patient and family-centered care coordination that integrates physical, oral, mental health and community-based services.

NCQA CC 11—Referral Monitoring: *Monitors the timeliness and quality of the referral response.*

- **NS Health Information Technology 4.** Documented processes exist for exchanging health information across care settings, including an agreement about exchanging information, the types of information to be exchanged, time frames for exchanging information, and to what extent referrals are made electronically.

NCQA CC 12—Co-Management Arrangements: *Documents co-management arrangements in the patient's medical record.*

- **NS Medical Home—Care Coordination 1.** All CYSHCN have access to patient and family-centered care coordination that integrates physical, oral, mental health and community-based services.
 - **NS Medical Home—Care Coordination 2.** Care coordinators have ongoing relationships with families, medical care providers, and other partners in care.
 - **NS Medical Home—Pediatric Specialty Care 2.** The system encourages shared management of CYSHCN between pediatric primary care and specialty providers through payment models or other policies that promote improved integration among multiple systems.
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Appendix E. NCQA Standard 5: Care Coordination and Care Transitions (CC)—Part 2

The practice 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.

NCQA Standards							
National Standards for Systems of Care for CYSHCN	NCQA CC 14: Identifying Unplanned Hospital and ED Visits	NCQA CC 15: Sharing Clinical Information	NCQA CC 16: Post-Hospital/ED Visit Follow-up	NCQA CC 17: Acute Care After Hours Coordination	NCQA CC 18: Information Exchange During Hospitalization	NCQA CC 20: Care Plan Collaboration for Practice Transitions	NCQA CC 21: External Electronic Exchange of Information
Foundational Standards							
Identification, Screening, Assessment, and Referral			✓				
Access to Care							
Medical Home	✓	✓					
Community Based Services and Support							
Health Information Technology				✓	✓		✓
Transition to Adulthood						✓	
Quality Assurance and Improvement							

NCQA CC 14—Identifying Unplanned Hospital and ED Visits: *Systematically identifies patients with unplanned hospital admissions and emergency department visits.*

- **NS Medical Home—Medical Home Management 10.** The medical home conducts effective transitions of care between primary and specialty services, facilities, and providers and institutional settings to ensure preference for health services and sharing of information across systems.

NCQA CC 15—Sharing Clinical Information: *Shares clinical information with admitting hospitals and emergency departments.*

- **NS Medical Home—Medical Home Management 9.** The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.

NCQA CC 16—Post-Hospital/ED Visit Follow-up: *Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.*

- **NS Identification, Screening, Assessment, and Referral 10.** Protocols and documentation methods are in place for the child’s medical home to follow-up with the child and family to ensure referred services were accessed and to provide any assistance in accessing needed care, regardless of the original entity conducting a screening and referral.

NCQA CC 17—Acute Care After Hours Coordination: *Systematic ability to coordinate with acute care settings after office hours through access to current patient information.*

- **NS Health Information Technology 1.** Electronic health information should be accessible, retrievable, and available across systems and meet meaningful use requirements.
- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.
- **NS Health Information Technology 4.** Documented processes exist for exchanging health information across care settings, including an agreement about exchanging information, the types of information to be exchanged, time frames for exchanging information, and to what extent referrals are made electronically.

NCQA CC 18—Information Exchange During Hospitalization: *Exchanges patient information with the hospital during a patient’s hospitalization.*

- **NS Health Information Technology 1.** Electronic health information should be accessible, retrievable, and available across systems and meet meaningful use requirements.
- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.

NCQA CC 20—Care Plan Collaboration for Practice Transitions: *Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).*

- **NS Transition to Adulthood—Pediatric Health Care Setting 1. Transition Policy:** A policy about transition is developed and in place at all levels of the system. It should be developed with consumer input and shared and discussed with youth and families beginning at ages 12-14 and regularly reviewed as part of ongoing care.
- **NS Transition to Adulthood—Pediatric Health Care Setting 3. Transfer of Care:** The system should be sure providers make the following documents available to the youth’s new provider who serves adult patients (adult provider): a) cover letter, b) final transition readiness assessment, c) updated plan of care, d) updated medical summary and emergency care plan, and e) if needed, legal documents, condition fact sheet, and additional provider records. There should also be a process in place to confirm with the adult provider residual responsibility for patient care until the young adult is seen in the adult care setting.

NCQA CC 21—External Electronic Exchange of Information: *Demonstrates electronic exchange of information with external entities, agencies and registries.*

- **NS Health Information Technology 2.** Medical homes have the capacity for electronic health information and exchange, including maintenance of clinical information.
- **NS Health Information Technology 4.** Documented processes exist for exchanging health information across care settings, including an agreement about exchanging information, the types of information to be exchanged, time frames for exchanging information, and to what extent referrals are made electronically.

Appendix F. NCQA Standard 6: Performance Measurement and Quality Improvement (QI)

The practice 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.

NCQA Standards													
National Standards for Systems of Care for CYSHCN	NCQA QI 01: Clinical Quality Measures	NCQA QI 02: Resource Stewardship Measures	NCQA QI 04: Patient Experience Feedback	NCQA QI 05: Health Disparities Assessment	NCQA QI 06: Validated Patient Experience Survey Use	NCQA QI 07: Vulnerable Patient Feedback	NCQA QI 08: Goals & Actions to Improve Clinical Quality Measures	NCQA QI 09: Goals & Actions to Improve Resource Stewardship Measures	NCQA QI 11: Goals & Actions to Improve Patient Experience	NCQA QI 12: Improved Performance	NCQA QI 13: Goals & Actions to Improve Disparities in Care/Service	NCQA QI 14: Improved Performance for Disparities in Care/Service	NCQA QI 17: Patients/Family Caregiver Involvement in Quality Improvement
Foundational Standards													
Identification, Screening, Assessment, and Referral													
Access to Care													
Medical Home													
Community Based Services and Support													
Health Information Technology													
Transition to Adulthood													
Quality Assurance and Improvement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

NCQA QI 01—Clinical Quality Measures: *Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type); Immunization measures; other preventive care measures; chronic or acute care clinical measures; and behavioral health measures.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: assessment of child outcomes, including measures of health and functional status.

NCQA QI 02—Resource Stewardship Measures: *Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): measures related to care coordination and measures affecting health care costs.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups) to obtain feedback and assess their experiences with care.
- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: assessment of out of pocket expenses, lost work burden and other sources of stress on families.

NCQA QI 04—Patient Experience Feedback: *Monitors patient experience through quantitative data (conducts a survey to evaluate patient/family/caregiver experiences across at least three dimensions; such as access, communication, coordination, whole-person care, self-management support, and comprehensiveness) and qualitative data (obtains feedback from patients/families/caregivers through qualitative means).*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups) to obtain feedback and assess their experiences with care.

NCQA QI 05—Health Disparities Assessment: *Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): clinical quality and patient experience.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups) to obtain feedback and assess their experiences with care.

NCQA QI 06—Validated Patient Experience Survey Use: *The practice uses a standardized, validated patient experience survey tool with benchmarking data available.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: periodic monitoring of utilization of care, appropriateness of care, and compliance with all system standards for CYSHCN.

NCQA QI 07—Vulnerable Patient Feedback: *The practice obtains feedback on experiences of vulnerable patient groups.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: families of CYSHCN are represented on the primary care provider QI teams and health plan QI teams
- **NS Quality Assurance and Improvement 2.** Child medical record reviews include a representative sample of CYSHCN so that the experiences of this population are reflected in QA and QI activities.

NCQA QI 08—Goals and Actions to Improve Clinical Quality Measures: *Sets goals and acts to improve upon at least three measures across at least three of the four categories: immunization measures; other preventive care measures; chronic or acute care clinical measures; and behavioral health measures.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place.

NCQA QI 09—Goals and Actions to Improve Resource Stewardship Measures: *Sets goals and acts to improve performance on at least one measure of resource stewardship, related to care coordination and/or affecting health care costs.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: periodic monitoring of utilization of care, appropriateness of care, and compliance with all system standards for CYSHCN.

NCQA QI 11—Goals and Actions to Improve Patient Experience: *Sets goals and acts to improve performance on at least one patient experience measure.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: families of CYSHCN are represented on the primary care provider QI teams and health plan QI teams.
- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups) to obtain feedback and assess their experiences with care.

NCQA QI 12—Improved Performance: *Achieves improved performance on at least two performance measures.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: assessment of child outcomes, including measures of health and functional status.
- **NS Quality Assurance and Improvement 2.** Child medical record reviews include a representative sample of CYSHCN so that the experiences of this population are reflected in QA and QI activities.

NCQA QI 13—Goals and Actions to Improve Disparities in Care/Service: *Sets goals and acts to improve disparities in care or services on at least one measure.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups) to obtain feedback and assess their experiences with care.

NCQA QI 14—Improved Performance for Disparities in Care/Service: *Achieves improved performance on at least one measure of disparities in care or service.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: conducting experience of care surveys of families of CYSHCN and youth (including targeted feedback from relevant racial/ethnic and language groups) to obtain feedback and assess their experiences with care.

NCQA QI 17—Patients/Family Caregiver Involvement in Quality Improvement: *Involves patient/family/caregiver in quality improvement activities.*

- **NS Quality Assurance and Improvement 1.** The state, health plans, providers and insurers have a specific and ongoing quality assurance (QA) and quality improvement (QI) process in place. This includes: families of CYSHCN are represented on the primary care provider QI teams and health plan QI teams.