NCQA PCMH 2014 – 2017

Crosswalk by Element

***2014 Critical Factors and Must Pass Elements highlighted in Red**

PCMH 2014 Standard 1			
PCMH 2014	**PCMH 2017**	**Content**	**Evidence**
Element 1A – Must Pass			
1A1	AC 02 (Core)	Same day access for urgent and routine during business hours	Documented process **AND** evidence of implementation
1A2	AC 03 (Core)	Same day access for urgent and routine after business hours	Documented process **AND** evidence of implementation
1A3	AC 06 (1 Credit)	Alternative visit types using technology-supported scheduled visit	Documented process **AND** report
1A4	QI 03 (Core)	Monitor availability of important visit types	Documented process **AND** report
1A5	No equivalent- Monitors No Shows		
1A6	QI 10 (Core)	Uses QI methods to improve access to care to meet patient needs and preference	Report **OR** Quality Improvement Worksheet
Element 1B			
1B1	AC 12 (2 Credits)	Provides continuity of medical record information when the office is closed	Documented process
1B2	AC 04 (Core)	Providing timely clinical advice by phone	Documented process **AND** report
1B3	AC 08 (1 Credit)	Providing timely 2-way electronic communication with the practice. Combines 1B3 and 1C5	Documented process **AND** report
1B4	AC 05 (Core)	Documenting clinical advice in the medical record and reconciling the same	Documented process **AND** evidence of implementation
Element 1C			
1C1-4	No equivalent - MU Stage 2 requirement regarding capability of patient electronic access, view, download, secure messaging		NA
1C5	AC 08	See 1B3 – Provides evidence of two-way electronic communication with patients.	Documented process **AND** report
1C6	AC 07 (1 Credit)	Patients can request appointments, refills, referrals and test results electronically	Evidence of implementation

PCMH 2014 Standard 2			
PCMH 2014	**PCMH 2017**	**Content**	**Evidence**
Element 2A			
2A1	AC 10 (Core)	Assisting patients in selecting a personal clinician	Documented process
2A2	AC 11 (Core)	Monitoring continuity with selected clinician or team	Report
2A3	TC 09 (Core)	Having a process to orient patients to the practice	Documented process **AND** evidence of implementation
2A4	CC 20 (1 Credit)	Develops a transitional care plan from pediatrics to adult for patients with complex care needs	Evidence of implementation
Element 2B			
2B1-5	TC 09 (Core)	See 2A3 – Process for orienting new patients to practice including materials used for orientation	Documented process **AND** evidence of implementation
2B6-8	No equivalent - Provides equal access regardless of ability to pay, provides information on how to obtain coverage, provides information on transfer of medical records		**NA**
Element 2C			
2C1	KM 09 (Core)	Assessing diversity of the population	Report
2C2	KM 10 (Core)	Assessing language needs	Report
2C3-4	No equivalent - Provides interpreter services and materials in the languages of the populations served		**NA**
Element 2D – Must Pass			
2D1-2	TC 02 (Core)	Defining care team roles and structure	Staff structure overview **AND** description of staff roles, skills and responsibilities
2D3	TC 06 (Core)	Process for care team structured communication	Documented process **AND** evidence of implementation
2D4-8	No equivalent - Uses standing orders, educates the care team, holds regular meetings to address practice functioning		**NA**
2D9	TC 07 (Core)	Involves care team staff in QI	Documented process **AND** evidence of implementation
2D10	QI 17 (2 credits)	Involves patients/families in QI	Documented process **AND** evidence of implementation

PCMH 2014 Standard 3			
PCMH 2014	**PCMH 2017**	**Content**	**Evidence**
Element 3A			
3A1-14	No equivalent – The practice uses an electronic system to record information in structured data fields		**NA**
Element 3B			
3B1	KM 01 (Core)	Documents an up-to-date problem list for each patient	Report **OR** KM 06-predominant conditions and health concerns
3B2-8, 10, 11	No equivalent – Records clinical data in structured data		**NA**
3B9	KM 15 (Core)	Documents medication list with dates of update	Report
Element 3C			
3C1	No equivalent – assesses age and gender appropriate immunizations and screenings		**NA**
3C2-8	KM 02 (Core)	Comprehensive health assessment including assessment of social interactions (new) and social determinants of health (new)	Documented process **AND** evidence of implementation
3C9	KM 03 (Core)	Depression screening for adults and adolescents	Evidence of implementation **AND** report **or** documented process
3C10	KM 11B (1 Credit)	Address health literacy of staff	Evidence of implementation
Element 3D – Must Pass			
3D1-4	KM 12 (Core)	Proactive outreach for needed services	Report/list **AND** outreach materials or KM 03 (new)
3D5	No equivalent - Outreach to patients regarding medication monitoring or alert		**NA**
Element 3E			
3E1, 2-6	KM 20 (Core)	Implements clinical decision support following evidence-based guidelines	Identifies conditions, source of guidelines **AND** evidence of implementation

PCMH 2014 Standard 4			
PCMH 2014	**PCMH 2017**	**PCMH 2014 – 2017 Alignment**	**Evidence**
Element 4A			
4A1-5	CM 01 (Core)	Systematically identifies patients who may benefit from care management	Protocol for identifying patients for care management **OR** CM03 (new)
4A6	CM 02 (Core)	The practice monitors the percentage of total patients identified for care management through its process and criteria	Report
Element 4B – Must Pass			
4B1	CM 06 (1 Credit)	Documents patient preferences and lifestyle goals for all patients in care management	Report **OR** record review workbook ***and*** patient examples
4B2	CM 04 (Core)	Establishes a person-centered care plan for patients identified for care management	Report **OR** record review workbook ***and*** patient examples
4B3	CM 07 (1 Credit)	Identifies and discuses barriers to meeting goals	Report **OR** record review workbook ***and*** patient examples
4B4	CM 08 (1 Credit)	Includes a self-management plan in individual care plans	Report **OR** record review workbook ***and*** patient examples
4B5	CM 05 (Core)	Provides a written care plan to patient/family/caregiver	Report **OR** record review workbook ***and*** patient examples
Element 4C			
4C1-2	KM 14 (Core)	Reviews and reconciles medication list	Report
4C3-4	KM 16 (1 Credit)	Assesses understanding and provides education as needed on new prescriptions	Report **AND** evidence of implementation
4C5	KM 17 (1 Credit)	Assesses and addresses response to medications and barriers to adherence	Report **AND** evidence of implementation
4C6	KM 15 (Core)	Maintains an up-to-date med list	Report
Element 4D			
4D1-4	No equivalent – Uses e-prescribing		**NA**
Element 4E			
4E1	No equivalent – Uses an EHR to identify patient-specific educational resources		**NA**

PCMH 2014	PCMH 2017	Content	Evidence
4E4	KM 24 (1 Credit)	Adopts shared decision making aids for preference-sensitive conditions	Evidence of implementation
4E5	KM 26 (1 Credit)	Maintains a list of community resources based on identified needs	List of resources
4E6	KM 27 (1 Credit)	Assess the usefulness of identified community support resources	Evidence of implementation

PCMH 2014 Standard 5			
PCMH 2014	**PCMH 2017**	**Content**	**Evidence**
Element 5A			
5A1, 2, 3-5	CC 01 (Core)	Tracks lab and imaging tests until results are available, flags abnormal lab and imaging results bringing them to the attention of the clinician, notifies patients/families of normal and abnormal lab and imaging results	Documented process **AND** evidence of implementation
5A6	CC 02 (1 Credit)	Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening	Documented process **AND** evidence of implementation
5A 7-10	No equivalent – electronic recording of lab and imaging orders, lab results are incorporated as structured data files, imaging results are electronically accessible.		**NA**
Element 5B – Must Pass			
5B1	CC 07 (2 Credits)	Considers available information on consultants/specialists when making referral recommendations	Data source **AND** examples
5B2	CC 08 (1 Credit)	Maintains formal and informal agreements with a subset of specialists based on established criteria	Documented process **OR** agreement
5B3	CC 09 (2 Credits	Maintains agreements with behavioral health providers	Agreement **OR** documented process ***and*** evidence of implementation
5B4	CC 10 (2 Credits)	Integrates behavioral health providers within the practice	Documented process **AND** evidence of implementation
5B5-6, 8	CC 04 (Core)	Gives the consultant or specialist the clinical question, timing and type of referral, pertinent demographic data, test results, and current care plan. Tracks referrals until the report is available, flags and follows up on overdue reports.	Documented process **AND** evidence of implementation
5B7	CC 21C (1 of 3 Credits)	CC 21C combines 5B7 and 5C7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider.	Evidence of implementation

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5B9	CC12 (1Credit)	Documents co-management arrangements in the patient's medical record	Evidence of implementation
5B10	No equivalent – Asks patients and families about self referrals and requests reports from clinicians		**NA**
Element 5C			
5C1	CC 14 (Core)	Systematically identifies patients with unplanned hospitalizations and ED visits	Documented process **AND** report
5C2	CC 15 (Core)	Shares clinical information with admitting hospitals and emergency departments	Documented process **AND** evidence of implementation
5C3	CC 19 (1 Credit)	Implements a process to systematically obtain discharge summaries from the hospital or other facilities	Documented process **AND** evidence of implementation
5C4	CC 16 (Core)	Contacts patients/families for follow up care, if needed, within an appropriate period following a hospital admission or ED visit	Documented process **AND** evidence of follow-up
5C5	CC 18 (1 Credit)	Exchanges information with the hospital during a patient's hospitalization	Documented process **AND** evidence of implementation
5C6	No equivalent – Obtains proper consent for release of information and has a process for secure exchange of information with community partners		NA
5C7	CC21C (1 of 3 credits)	Same as 5B7 – CC 21C combines 5B7 and 5C7. Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider.	Evidence of implementation

PCMH 2014 Standard 6			
PCMH 2014	**PCMH 2017**	**Content**	
Element 6A			
6A1-3	QI 01 (Core)	Monitors at least 5 clinical quality measures; behavioral health measure is new.	Report
6A4	QI 05 (1 Credit)	Assesses health disparities using performance data stratified for vulnerable populations	Report **OR** Quality Improvement Worksheet
Element 6B			
6B1-2	QI 02 (Core)	Monitors at least 2 measures of resource stewardship	Report
Element 6C			
6C1	QI 04A (Core)	Monitors patient experience through quantitative data	Report
6C2	QI 06 (1 Credit)	The practice uses a standardized, validated patient experience tool with benchmarking data available	Report
6C3	QI 07 (2 Credits)	The practice obtains feedback on experience of vulnerable patient groups	Report
6C4	QI 04B (Core)	Obtains feedback from patient/families/caregivers through qualitative means	Report
Element 6D – Must Pass			
6D1-2	QI 08 (Core)	Sets goals and acts to improve on at least three measures across 3 categories, includes behavioral health (new)	Report **OR** Quality Improvement Worksheet
6D3-4	QI 09 (Core)	Sets goals and acts to improve on at least one measure of resource stewardship	Report **OR** Quality Improvement Worksheet
6D5-6	QI 11 (Core)	Sets goals and acts to improve at least one patient experience measure	Report **OR** Quality Improvement Worksheet
6D7	QI 13 (1 Credit)	Sets goals and acts to improve at least one measure of disparities in care or service	Report **OR** Quality Improvement Worksheet

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Element 6E			
6E1	No equivalent – Measuring the effectiveness of actions taken in 6D		**NA**
6E2-4	QI 12 (2 Credits)	Achieves improved performance on at least 2 of 5 performance measures – clinical, utilization, patient experience	Report **OR** Quality Improvement Worksheet
Element 6F			
6F1-2	QI 15 (Core)	Reports practice-level or individual clinician performance results within the practice for measures reported by the practice	Documented process **AND** evidence of implementation
6F3-4	QI 16 (1 Credit)	Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice	Documented process **AND** evidence of implementation
Element 6G			
6G1-2	TC 05 (2 Credits)	Uses a certified EHR, conducts security risk assessments	Certified Electronic Health Record (name)
6G3-5	No equivalent – submits electronic syndromic data, reports to cancer registries, or other specific disease registries		**NA**
6G6	QI 18 (2 Credits)	Reports clinical quality measures to Medicare or Medicaid as required by Meaningful Use	Evidence of submission
6G7	CC21B (1 of 3 Credits)	Submits electronic data to immunization registries	Evidence of implementation
6G8-9	CC21A (1 of 3 Credits)	Exchanges health data as part of an RIO or other health information exchange	Evidence of implementation
6G10	KM 12 (Core)	See 3D 1-4, generates lists of patients, and based on their preferred method of communication, sends proactive reminders about needed services	Report/list **AND** outreach materials