Transition Document for NCQA 2014 Standards Compared to NCQA 2017 Concepts

Updated 5/1/17

NCQA 2014 Factors and related NCQA 2017 Criteria	
NCQA 2014, Standard 1	**2017 Criteria**
PCMH 1: Patient-Centered Access – Patient-Centered Appointment Access (MUST-PASS), Element A	**Matching NCQA 2017 Criteria**
1:A:1 (Critical Factor) Providing same-day appointments for routine and urgent care	**AC-02 (Core):** The practice reserves time on the daily appointment schedule to accommodate patient requests for a same-day appointment for routine or for urgent care needs.
1:A:2 Providing routine and urgent-care appointments outside regular business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch.	**AC-03 (Core):** The practice offers routine and urgent care appointments outside typical business hours. Example: opening at 7am, staying open until 7pm on certain days, open on alternating Saturdays, etc. It does not count if a clinic stays open when they would normally be closed for lunch.
1:A:3 Provides alternative types of clinical encounters.	**AC-06 (1 Credit):** Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms. **KM-22 (1 Credit):** Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
1:A:4 The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: Availability of appointments.	**QI-03 (Core):** Assesses performance on availability of major appointment types to meet patient needs and preferences for access.
1:A:5 Monitoring no-show rates.	**NO MATCHING 2017 CRITERIA**
1:A:6 The clinic acts on identified opportunities to improve access.	**QI-10 (Core):** Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.
PCMH 1: Patient-Centered Access – 24/7 Access To Clinical Advice, Element B	**Matching NCQA 2017 Criteria**
1:B:1 Provides continuity of medical record information for care and advice when office is closed.	**AC-12 (2 Credits):** Provides continuity of medical record information for care and advice when the office is closed.
1:B:2 (Critical Factor) Providing timely clinical advice by telephone	**AC-04 (Core):** Provides timely clinical advice by telephone.
1:B:3 Providing timely clinical advice using a secure, interactive electronic system.	**NO MATCHING 2017 CRITERIA (although, it is closely related to AC-04).**

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Eastern Idaho Public Health
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NCQA 2014, Standard 1	2017 Criteria
1:B:4 Documenting clinical advice in patient records. It reconciles this information with the medical record the next business day.	**AC-05 (Core):** Practice documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.
PCMH 1: Patient-Centered Access- Electronic Access, Element C	**Matching NCQA 2017 Criteria**
1:C: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.	**NO MATCHING 2017 CRITERIA**
1:C: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.	**NO MATCHING 2017 CRITERIA**
1:C:3 Clinical summaries are provided within 1 business day for more than 50 percent of office visits.	**NO MATCHING 2017 CRITERIA**
1:C:4 A secure message was sent by more than 5 percent of patients.	**NO MATCHING 2017 CRITERIA**
1:C:5 Practice has a secure, interactive electronic system, such as a website, patient portal, or a secure e-mail system that allows two-way communication between patients/families/caregivers, as applicable for a patient, and the practice.	**AC-08 (1 Credit):** has a secure electronic system for patient for two-way communication to provide timely clinical advice.
1:C:6 Patients can use the secure electronic system (e.g., website or patient portal) to request appointments, medication refills, referrals to other providers and get test results.	**AC-07 (1 Credit):** Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.

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NCQA 2014, Standard 2	2017 Criteria
PCMH 2: Team-Based Care – Continuity, Element A	**Matching NCQA 2017 Criteria**
2:A:1 Assists patients/families to select a personal clinician and documents the selection in practice records.	**AC-10 (Core):** Helps patients/families/caregivers select or change a personal clinician.
2:A:2 Monitors the percentage of patient visits with selected clinician or team.	**AC-11 (Core):** Sets goals and monitors the percentage of patient visits with the selected clinician or team.
2:A:3 Practice has a process to orient new patients to the practice and provides information about the medical home model, medical home responsibilities, and patient responsibilities and expectations.	**TC-09 (Core):** 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.
2:A:4 For pediatric practices transitions patients to adult care, the practice provides a written care plan to the adult practice. **(Related to CC-20 from 2017 Standards, but not exactly the same).**	**CC-20 (1 Credit):** 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).
PCMH 2: Team-Based Care – Medical Home Responsibilities, Element B	**Matching NCQA 2017 Criteria**
2:B:1 The practice is responsible for coordinating patient care across multiple settings.	**NO MATCHING 2017 CRITERIA, but related to CM-09:** Care Plan is integrated and accessible across settings of care.
2:B:2 Instructions for obtaining care and clinical advice during office hours and when the office is closed. **2:B:4** The care team provides access to evidence-based care, patient/family education and self-management support. **2:B:5** The scope of services available within the practice including how behavioral health needs are addressed. **2:B:8** Instructions on transferring records to the practice, including a point of contact at the practice.	**TC-09 (Core):** 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.
2:B:3 The practice functions more effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.	**NO MATCHING 2017 CRITERIA**
2:B:6 The practice provides equal access to all of their patients regardless of source of payment.	**NO MATCHING 2017 CRITERIA**
2:B:7 The practice gives uninsured patients information about obtaining coverage.	**NO MATCHING 2017 CRITERIA**

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NCQA 2014, Standard 2	2017 Criteria
PCMH 2: Team-Based Care – Culturally and Linguistically Appropriate Services, Element C	**Matching NCQA 2017 Criteria**
2:C:1 Assessing the diversity of its population	**AC-09 (1 Credit):** Uses information about the population served by the practice to assess equity of access that considers health disparities.
2:C:2 Assessing the language needs of its population.	**KM-08 (1 Credit):** Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials. **KM-10 (Core):** Assesses the language needs of its population.
2:C:3 Providing interpretation or bilingual services to meet the language needs of its population.	**KM-10 (Core):** Assesses the language needs of its population
2:C:4 Provides printed materials in the languages of its population **(related to requirements in 2017 Standards, TC-09 and KM-08)**	**TC-09 (Core):** 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. **KM-08 (1 Credit):** Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.
PCMH 2: Team-Based Care – The Practice Team (MUST-PASS), Element D	**Matching NCQA 2017 Criteria**
2:D:1 Defining roles for clinical and nonclinical team members. Job roles and responsibilities emphasize a team-based approach to care and support each member of the team being trained to meet the highest level of function allowed by state law.	**TC-02 (Core):** Defines practice organizations structure and staff responsibilities/skills to support key PCMH functions.
2:D:2 Identifying the team structure and the staff who lead and sustain team based care.	**Related to TC-01, but not exact.** **TC-01 (Core):** Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.
2:D:3 (Critical Factor) Practice holds scheduled patient care team meetings or has a structured communication process focused on individual patient care. (i.e. Huddles)	**TC-06 (Core):** Has regular patient care team meetings or a structured communication process focused on individual patient care. (i.e. Huddles)
2:D:4 Using standing orders for services.	**NO MATCHING 2017 CRITERIA**

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NCQA 2014, Standard 2	2017 Criteria
2:D:5 Training and assigning members of the care team to coordinate care for individual patients.	**NO DIRECTLY MATCHING 2017 CRITERIA**
2:D:6 Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior changes.	**NO DIRECTLY MATCHING 2017 CRITERIA**
2:D:7 Training and assigning members of the care team to manage the patient population.	**NO DIRECTLY MATCHING 2017 CRITERIA**
2:D:8 Holding scheduled team meetings to address practice functioning.	**NO DIRECTLY MATCHING 2017 CRITERIA**
2:D:9 Practice involves care team staff in the practice's performance evaluation and quality improvement activities.	**TC-07 (Core):** Involves care team staff in the practice's performance evaluation and quality improvement activities.
2:D:10 Practice involves patients/families/caregivers in quality improvement activities or on the practice's advisory council.	**TC-04 (2 Credits):** Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees. **QI-17 (2 Credits):** Involves patient/family/caregiver in quality improvement activities.

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NCQA 2014, Standard 3	2017 Criteria
PCMH 3: Population Health Management – Patient Information, Element A	**Matching NCQA 2017 Criteria**
3:A:1 The practice uses an electronic system to record patient date of birth.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:2 The practice uses an electronic system to record patient sex.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:3&4 The practice records patient race, ethnicity and other diversity data.	**KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:5 The practice documents the patient's preferred spoken/written language, which helps identify patients who need interpretation and translation services.	**KM-10 (Core):** Assesses the language needs of its population.
3:A:6 The practice uses an electronic system to record patient telephone numbers.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:7 The practice uses an electronic system to record patient E-mail address.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:8 The practice uses an electronic system to record patient occupation (NA for pediatric practices).	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:9 The practice uses an electronic system to record dates of previous clinical visits.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:10 The practice uses an electronic system to record patient's legal guardian/health care proxy.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.

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NCQA 2014, Standard 3	2017 Criteria
3:A:11 The practice uses an electronic system to record patient's primary care giver.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:12 The practice uses an electronic system to record presence of advance directives (NA for pediatric practices).	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:13 The practice uses an electronic system to record patient health insurance information.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
3:A:14 The practice uses an electronic system to record name and contact information of other health care professionals involved in patient's care.	**Not exactly matching, but part of KM-09 (Core):** Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.
PCMH 3: Population Health Management – Clinical Data, Element B	**Matching NCQA 2017 Criteria**
3:B:1 An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.	**KM-01 (Core):** Documents an up-to-date problem list for each patient with current and active diagnoses.
3:B:2 Allergies, including medication allergies and adverse reactions, for more than 80 percent of patients.	**NO MATCHING 2017 CRITERIA**
3:B:3 Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.	**NO MATCHING 2017 CRITERIA**
3:B:4 Height/length for more than 80 percent of patients.	**NO MATCHING 2017 CRITERIA**
3:B:5 Weight for more than 80 percent of patients.	**NO MATCHING 2017 CRITERIA**
3:B:6 System calculates and displays BMI.	**NO MATCHING 2017 CRITERIA**
3:B:7 System plots and displays growth charts (length/height, weight and head circumference) and BM percentile (0-20) (NA for adult practices).	**Not exactly matching, but part of KM-02 (Core): H.** Developmental screening using a standardized tool.
3:B:8 Status of tobacco use for patients 13 years and older for more than 80 percent of patients.	**KM-02 (Core):** Comprehensive health assessment includes B. mental health/substance use history of patient and family.
3:B:9 List of prescription medications with date of updates for more than 80 percent of patients.	**KM-15 (Core):** Maintains and up-to-date list of medications for more than 80 percent of patients.

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NCQA 2014, Standard 3	2017 Criteria
3:B:10 More than 20 percent of patients have family history recorded as structured data.	**KM-02 (Core):** Comprehensive health assessment includes A. Medical history of patient and family.
3:B: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.	**NO MATCHING 2017 CRITERIA**
PCMH 3: Population Health Management – Comprehensive Health Assessment, Element C	**Matching NCQA 2017 Criteria**
3:C:1-10 To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes (factors 1-10).	**KM-02 (Core):** Comprehensive health assessment includes A-I items (all items required).
3:C:6 Behaviors affecting health **3:C:7** Mental health/substance use history of patient and family. **These factors are related to 2017 Standards, KM-04, but are not exactly the same because the 2014 Standards don't require screening specifically for these conditions.**	**KM-04 (1 Credit):** Conducts behavioral health screening and/or assessments using a standardized tool. (Implement two or more). **A.** Anxiety, **B.** Alcohol us disorder, **C.** Substance use disorder, **D.** Pediatric behavioral health screening, **E.** Post-traumatic stress disorder, **F.** Attention deficit/hyperactivity disorder, **G.** Postpartum depression
3:C:9 Depression screening for adults and adolescents using a standardized tool.	**KM-03 (Core):** Conducts depression screenings for adults and adolescents using a standardized tool.
3:C:10 The practice assesses the patient/family/caregiver's ability to understand the concepts and care requirements associated with managing their health.	**KM-08 (1 Credit):** Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.
PCMH 3: Population Health Management – Use Data for Population Management (MUST-PASS), Element D	**Matching NCQA 2017 Criteria**
3:D: At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including: **3:D:1** At least two different preventive care services **3:D:2** At least two different immunizations **3:D:3** At least three different chronic or acute care services **3:D:4** Patients not recently seen by the practice	**KM-12 (Core):** The practice proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories): **A. Preventive care services** **B. Immunizations** **C. Chronic or acute care services** **D. Patients not recently seen by the practice.**

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NCQA 2014, Standard 3	2017 Criteria
3:D:5 Medication monitoring or alert **(Related to KM-15, but not exact).**	**KM-15 (Core):** Maintains an up-to-date list of medications for more than 80 percent of patients.
PCMH 3: Population Health Management – Implement Evidence-Based Decision Support, Element E	**Matching NCQA 2017 Criteria**
3:E:1-6 The practice implements clinical decision support (e.g. point-of-care reminders) following evidence-based guidelines for: **1.** A mental health or substance use disorder **(Critical Factor)**, **2.** A chronic medical condition, **3.** An acute condition, **4.** A condition related to unhealthy behaviors, **5.** Well child or adult care, **6.** Overuse/appropriateness issues.	**KM-20 (Core):** Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria): **A.** Mental health condition, **B.** Substance use disorder, **C.** A chronic medical condition, **D.** An acute condition, **E.** A condition related to unhealthy behaviors, **F.** Well child or adult care, **G.** Overuse/appropriateness issues.

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NCQA 2014, Standard 4	2017 Criteria
PCMH 4: Care Management and Support – Identify Patients for Care Management, Element A	**Matching NCQA 2017 Criteria**
4:A:1 The practice has specific criteria for identifying patients with behavioral conditions for whole-person care planning and management.	**TC-08 (2 Credits):** Has at least one care manager qualified to identify and coordinate behavioral health needs. **Criteria is related to this 2014 Factor, but in the 2014 standards, clinics were not asked to have a behavioral healthcare manager.**
4:A:1-5 The practice establishes a systematic process and criteria for identifying patients who may benefit from care management The process includes consideration of the following: **1.** Behavioral health conditions, **2.** High cost/high utilization, **3.** Poorly controlled or complex conditions, **4.** Social determinants, **5.** Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff or patient/family/caregiver.	**CM-01 (Core):** Considers the following 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): **A.** Behavioral health conditions, **B.** High cost/high utilization, **C.** Poorly controlled or complex conditions, **D.** Social determinants of health, **E.** Referrals by outside organizations (e.g. insurers, health system, ACO), practice staff, patient/family/caregiver.
4:A:6 (Critical Factor) The practice monitors the percentage of the total patient population identified through its process and criteria.	**CM-02 (Core):** Monitors the percentage of the total patient population identified through its process and criteria.
PCMH 4: Care Management and Support – Care Planning and Self-Care Support (MUST-PASS), Element B	**Matching NCQA 2017 Criteria**
4:B:1-3 The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes: **1.** Incorporates patient preferences and functional/lifestyle goals, **2.** Identifies treatment goals, **3.** Assesses and addresses potential barriers to meeting goals.	**CM-04 (Core):** Establishes a person-centered care plan for patients identified for care management.
4:B:1 The practice incorporates the patient preference and functional/lifestyle goals within the patient's care plan.	**CM-06 (1 Credit):** Documents patient preference and functional/lifestyle goals in individuals care plans.
4:B:3 The practice assesses and addresses potential barriers to meeting goals within the patient's care plan.	**CM-07 (1 Credit):** Identifies and discusses potential barriers to meeting goals in individual care plans.
4:B:4 The patient's care plan includes a self-management plan.	**CM-08 (1 Credit):** Includes a self-management plan in individual care plans.
4:B:5 Care plan is provided in writing to the patient/family/caregiver.	**CM-05 (Core):** Provides a written care plan to the patient/family/caregiver for patients identified for care management.

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NCQA 2014, Standard 4	2017 Criteria
PCMH 4: Care Management and Support – Medication Management, Element C	**Matching NCQA 2017 Criteria**
4:C:1 (Critical Factor) Reviews and reconciles medications for more than 50 percent of patients received from care transitions.	**KM- 14 (Core):** Reviews and reconciles medications for more than 80 percent of patients received from care transitions.
4:C:2 Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.	**KM- 14 (Core):** Reviews and reconciles medications for more than 80 percent of patients received from care transitions.
4:C:3 Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.	**KM- 16 (1 Credit):** Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.
4:C:4 Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.	**KM- 16 (1 Credit):** Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregivers.
4:C:5 Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.	**KM-17 (1 Credit):** Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.
4:C:6 Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.	**KM-15 (Core):** Maintains an up-to-date list of medications for more than 80 percent of patients. This includes over-the-counter medications and herbal and vitamin/mineral/dietary (nutritional) supplements.
PCMH 4: Care Management and Support - Use of Electronic Prescribing, Element D	**Matching NCQA 2017 Criteria**
The practice uses an electronic prescription system with the following capabilities: **4:D:1** More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies. **4:D:2** Enters electronic medication orders in the medical record for more than 60 percent of medications. **4:D:3** Performs patient-specific checks for drug-drug and drug-allergy interactions. **4:D:4** Alerts prescribers to generic alternatives.	**4:D:1-4** are related to **KM-14-19,** but are not exact. **KM-14-19:** The practice addresses medication safety and adherence by providing information to the patient and establishing processes for medication documentation, reconciliation, and assessment of barriers.

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NCQA 2014, Standard 4	2017 Criteria
PCMH 4: Care Management and Support – Support Self-Care and Shared Decision Making, Element E	**Matching NCQA 2017 Criteria**
The practice has, and demonstrates use of materials to support patients and families/caregivers in self-management and shared decision making. The practice **4:E:1** Uses an EMR to identify patient-specific education resources and provide them to more than 10 percent of patients.	**NO MATCHING 2017 CRITERIA**
4:E:2 Provides educational materials and resources to patients.	**KM-22 (1 Credit):** Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
4:E:3 Provides self-management tools to record self-care results.	**NO MATCHING 2017 CRITERIA**
4:E:4 Adopts shared decision making aids.	**KM-24 (1 Credit):** Adopts shared decision-making aids for preference-sensitive conditions.
4:E:5 Offers or refers patients to structured health education programs, such as group classes and peer support.	**KM-22 (1 Credit):** Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
4:E: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.	**KM-26 (1 Credit):** Routinely maintains a current community resource list based on the needs identified in KM-21.
4:E:7 Assess usefulness of identified community resources.	**KM-27 (1 Credit):** Assesses the usefulness of identified community support resources.

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NCQA 2014, Standard 5	2017 Criteria
PCMH 5: Care Coordination and Care Transitions – Test Tracking and Follow-Up, Element A	**Matching NCQA 2017 Criteria**
The practice has a documented process for and demonstrates that it: **5:A:1 (Critical Factor)** Tracks lab tests until results are available, flagging and following up on overdue results. **5:A:2 (Critical Factor)** Tracks imaging tests until results are available, flagging and following up on overdue results. **5:A:3** Flags abnormal lab results, bringing them to the attention of the clinician. **5:A:4** Flags abnormal imaging results, bringing them to the attention of the clinician. **5:A:5** Notifies patients/families of normal and abnormal lab and imaging test results.	**CC-01 (Core):** The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result. (This process includes tracking, flagging abnormal results, and notifying patients/families of normal and abnormal lab and imaging tests.
5:A:6 Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).	**CC-02 (1 Credit):** Follows up with the inpatient facility about newborn hearing and blood-spot screening.
5:A:7 More than 30 percent of laboratory orders are electronically recorded in the patient record.	**5:A: 6-10 are related to CC-01, A-F, but not exact and do not cross over completely.**
5:A:8 More than 30 percent of radiology orders are electronically recorded in the patient record.	
5:A:9 Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.	
5:A:10 More than 10 percent of scans and tests that result in an image are accessible electronically.	
PCMH 5: Care Coordination and Care Transitions – Referral Tracking and Follow-Up (MUST-PASS), Element B	**Matching NCQA 2017 Criteria**
5:B:1 Considers available performance information on consultants/specialists when making referral recommendations.	**CC-07 (2 Credits):** Considers available performance information on consultants/specialists when making referrals.
5:B:2 Maintains formal and informal agreements with a subset of specialists based on established criteria.	**CC-08 (1 Credit):** Works with non-behavioral healthcare specialist to whom the practice frequently refers to set expectations for information sharing and patient care.

NCQA 2014, Standard 5	2017 Criteria
5:B:3 Maintains agreements with behavioral healthcare providers.	**CC-09 (2 Credits):** Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.
5:B:4 Integrates behavioral healthcare providers within the practice site.	**CC-10 (2 Credits):** Integrates behavioral healthcare providers into the care delivery system of the practice site.
5:B:5 Gives the consultant or specialist the clinical question, the required timing and the type or referral. **5:B:6** Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan. **5:B:8 (Critical Factor)** Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.	**CC-04 (Core):** The practice systematically manages referrals by: **A.** Giving the consultant or specialist the clinical questions, the required timing and the type of referral, **B.** Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan, **C.** Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.
5:B: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.	**Related to CC-21 (Maximum 3 Credits):** Demonstrates electronic exchange of information with external entities, agencies and registries.
5:B:9 Documents co-management arrangements in the patient's medical record.	**CC-12 (1 Credit):** Documents co-management arrangements in the patient's medical record.
5:B:10 Asks patients/families about self-referrals and requesting reports from clinicians.	**NO MATCHING 2017 CRITERIA**
PCMH 5: Care Coordination and Care Transitions – Coordinate Care Transitions, Element C	**Matching NCQA 2017 Criteria**
5:C:1 Proactively identifies patients with unplanned hospital admissions and emergency department visits.	**CC-14 (Core):** Systematically identifies patients with unplanned hospital admissions and emergency department visits.
5:C:2 Shares clinical information with admitting hospitals and emergency departments.	**CC-15 (Core):** Shares clinical information with admitting hospitals and emergency departments.
5:C:3 Consistently obtains patient discharge summaries from the hospital and other facilities.	**CC-19 (1 Credit):** Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.
5:C:4 Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.	**CC-16 (Core):** Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

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NCQA 2014, Standard 5	2017 Criteria
5:C:5 Exchanges patient information with the hospital during a patient's hospitalization.	**CC-18 (1 Credit):** Exchanges patient information with the hospital during a patient's hospitalization.
5:C:6 Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners.	**NO MATCHING 2017 CRITERIA**
5:C: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.	**CC-21 (Maximum Credits)**: **(C)** Making the summary of care record accessible to another provider or care facility for care transitions.

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NCQA 2014, Standard 6	2017 Criteria
PCMH 6: Performance Measurement and Quality Improvement – Measure Clinical Quality Performance, Element A	**Matching NCQA 2017 Criteria**
At least annually, the practice measures or receives data on: **6:A:1** At least two immunization measures **(A)** **6:A:2** At least two other preventive care measures **(B)** **6:A:3** At least three chronic or acute care clinical measures **(C)** **NO RELATED 2014 FACTOR to match OQ-01 (Core): (D)**	**QI-01 (Core):** Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type): **A.** Immunization measure, **B.** Other preventive care measures, **C.** Chronic or acute care clinical measures, **D.** Behavioral health measures.
6:A:4 Performance data stratified for vulnerable populations (to assess disparities in care).	**QI-05 (1 Credit):** Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): **A:** Clinical Quality **B:** Patient Experience
PCMH 6: Performance Measurement and Quality Improvement – Measure Resource Use and Care Coordination, Element B	**Matching NCQA 2017 Criteria**
At least annually, the practice measures or receives quantitative data on: **6:B:1** At least two measures related to care coordination **(A)** **6:B:2** At least two utilization measures affecting health care costs **(B)**	**QI-02 (Core):** Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): **A.** Measures related to care coordination. **B.** Measures affecting health care costs.
PCMH 6: Performance Measurement and Quality Improvement – Measure Patient/Family Experience, Element C	**Matching NCQA 2017 Criteria**
At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care. **6:C:1** The practice conducts a survey to evaluate patient/family experiences on at least three of the following categories: Access, Communication, Coordination, Whole person care/self-management support. **(A)** **6:C:4** The practice obtains feedback from patients/families through qualitative means. **(B)**	**QI-04 (Core):** Monitors patient experience through: **A.** 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. **B.** Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.
6:C:2 The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool.	**QI-06 (1 Credit):** The practice uses a standardized, validated patient experience survey tool with benchmarking data available.
6:C:3 The practice obtains feedback on experiences of vulnerable patient groups.	**QI-07 (2 Credits):** The practice obtains feedback on experiences of vulnerable patient groups.

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NCQA 2014, Standard 6	2017 Criteria
PCMH 6: Performance Measurement and Quality Improvement – Implement Continuous Quality Improvement (MUST-PASS), Element D	**Matching NCQA 2017 Criteria**
The practice uses an ongoing quality improvement process to: **6:D:1** Set goals and analyze at least three clinical quality measures from Element A (immunizations, preventive care, and chronic or acute clinical measures). **6:D:2** Act to improve at least three clinical quality measures from Element A (immunizations, preventive care, and chronic or acute clinical measures).	**QI-08 (Core):** Sets goals and acts to improve upon at least three measures across at least three of the four categories: **A.** Immunization measures, **B.** Other preventive care measures, **C.** Chronic or acute care clinical measures, **D.** Behavioral health measures
The practice uses an ongoing quality improvement process to: **6:D:3** Set goals and analyze at least one measure from Element B (measures related to care coordination or measures affecting health care costs). **6:D:4** Act to improve at least one measure from Element B (measures related to care coordination or measures affecting health care costs).	**QI-09 (Core):** Sets goals and acts to improve performance on at least one measure of resource stewardship: **A.** Measures related to care coordination **B.** Measures affecting health care costs.
6:D:5 The practice uses an ongoing quality improvement process to: Set goals and analyze at least on patient experience measure.	**QI-11 (Core):** Sets goals and acts to improve performance on at least one patient experience measure.
6:D:6 Act to improve at least one patient experience measure from Element C.	**QI-11 (Core):** Sets goals and acts to improve performance on at least one patient experience measure
6:D:7 Set goals and address at least one identified disparity in care/service for identified vulnerable populations.	**QI-13 (1 Credits):** Sets goals and acts to improve disparities in care or services on at least one measure.
PCMH 6: Performance Measurement and Quality Improvement – Demonstrate Continuous Quality Improvement, Element E	**Matching NCQA 2017 Criteria**
6:E:1 Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.	**NO MATCHING 2017 CRITERIA**
6:E:2 Achieving improved performance on at least two clinical quality measures. **6:E:3** Achieving improved performance on one utilization or care coordination measure. **6:E:4** Achieving improved performance on at least one patient experience.	**QI-12 (2 Credits):** Achieves improved performance on at least two performance measures.

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NCQA 2014, Standard 6	2017 Criteria
PCMH 6: Performance Measurement and Quality Improvement – Report Performance, Element F	**Matching NCQA 2017 Criteria**
The practice produces performance data reports using measures from Elements A, B, and C and shares: **6:F:1** Individual clinician performance results with the practice **6:F:2** Practice-level performance results with the practice. **6:F:3** Individual clinician or practice-level performance results publicly. **6:F:4** Individual clinician or practice-level performance results with patients.	**QI-15 (Core):** Reports practice-level or individual clinician performance results within the practice for measures reported by the practice. **QI-16 (1 Credit):** Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice. **KM-13 (2 Credits):** Demonstrates excellence in a benchmarked/performance-based recognition program assessed using evidence-based care guidelines.
PCMH 6: Performance Measurement and Quality Improvement – Use Certified EMR Technology, Element G	**Matching NCQA 2017 Criteria**
6:G:1 The practice uses an EMR system (or modules) that has been certified and issued a CMS certification ID.	**NO MATCHING 2017 CRITERIA**
6:G:2 The practice conducts a security risk analysis of its EMR system (or modules), implements security updates as necessary and corrects identified security deficiencies.	**NO MATCHING 2017 CRITERIA**
6:G:3 The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.	**NO MATCHING 2017 CRITERIA**
6:G:4 The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.	**NO MATCHING 2017 CRITERIA**
6:G:5 The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.	**NO MATCHING 2017 CRITERIA**
6:G:6 The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use.	**QI-18 (2 Credits):** Reports clinical quality measures to Medicare or Medicaid agency.

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NCQA 2014, Standard 6	2017 Criteria
6:G:7 The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically. **(B)** **6:G:8** The practice has access to a health information exchange. **(A)** **6:G:9** The practice has bidirectional exchange with a health information exchange. **(A)** **5:C: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. **(C)**	**CC-21 (Maximum 3 Credits):** Demonstrates electronic exchange of information with external entities, agencies, and registries (May select one or more): **A.** Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. **(1 Credit)** **B.** Immunization registries or immunization information systems. **(1 Credit)** **C.** Summary of care record to another provider or care facility for care transitions. **(1 Credit)**
6:G: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. **(Similar to KM-12 on 2017 Standards, but not the same).**	**KM-12 (Core):** The practice proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories): **A. Preventive care services** **B. Immunizations** **C. Chronic or acute care services** **D. Patients not recently seen by the practice.**

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