Appendix 4

PCMH 2011-PCMH 2014 Crosswalk

APPENDIX 4

PCMH 2011–PCMH 2014 Crosswalk

The table below compares NCQA's Patient-Centered Medical Home (PCMH) 2011 standards with NCQA's Patient-Centered Medical Home (PCMH) 2014 standards. The column on the right identifies the items that are the same or similar and calls out differences when they exist.

Meaningful Use Alignment

The Patient-Centered Medical Home (PCMH) 2014 recognition program was developed to align with Meaningful Use Stage 2. Alignment has been updated to reflect the Meaningful Use Modified Stage 2 Final Rule released in October 2015.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
PCMH 1: Enhance Access and Continuity The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/ families. ***20 points***	**PCMH 1:Patient-Centered Access** The practice provides access to team-based care for both routine and urgent needs of patients/ families/caregivers at all times. ***10 points***	
MUST-PASS **CRITICAL FACTOR = FACTOR 1** **Element 1A: Access During Office Hours** ***4 points*** The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: 1. Providing same-day appointments 2. Providing timely clinical advice by telephone during office hours 3. Providing timely clinical advice by secure electronic messages during office hours 4. Documenting clinical advice in the patient medical record **Documentation** • *Factors 1-4:* Documented process for scheduling appointments, providing and documenting clinical advice.	**MUST-PASS** **CRITICAL FACTOR = FACTOR 1** **Element 1A: Patient-Centered Appointment Access** ***4.5 points*** The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care 2. Providing routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no show rates 6. Acting on identified opportunities to improve access **Documentation** • *Factors 1-6:* Dated documented process and • *Factor 1:* Report with at least 5 days of data showing same-day access.	• *General:* Factors in PCMH 2011, Elements A and B have been separated into categories more specific to their focus in PCMH 2014 Elements A and B. • PCMH 2011 Element A, factor 1 aligns with PCMH 2014 Element A, factor 1, with these differences: – *PCMH 2011*: Evaluates same-day appointments. – *PCMH 2014:* Evaluates same-day appointments for routine and urgent care. • PCMH 2011 Element A, factor 2 aligns with PCMH 2014 Element B, factor 2, with these differences: – *PCMH 2011*: Evaluates advice by telephone during office hours. – *PCMH 2014:* Evaluates advice by telephone 24/7. • PCMH 2011 Element A, factor 3 aligns with PCMH 2014 Element B, factor 3, with these differences: *PCMH 2011:* Evaluates advice by secure electronic messages during office hours. *PCMH 2014:* Evaluates advice by secure electronic messages 24/7.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factors 1-3:* Reports with 5 days of data showing same-day access, response times compared with practice-defined standards. • *Factor 4:* Three examples of clinical advice or report with percentage of documented advice in record in recent 1-month period. **Scoring** 100%: 4 factors 75%: 3 factors (including factor 1) 50%: 2 factors (including factor 1) 25% Factor 1 (not 1 factor) 0%: 0 factors or missing factor 1	• *Factor 2:* Report showing at least five days of data ***or*** materials provided to patients. • *Factor 3:* Report with frequency of scheduled alternative encounter types in a recent 30-calendar day period. • *Factor 4*: Report with at least 5 days of data showing appointment wait times compared to practice defined standards including a policy for how the practice monitors appointment availability. • *Factor 5:* Report showing rate of no shows from a recent 30-day period. • *Factor 6:* A report showing selected an opportunity and took action to improve access. **Scoring** 100%: 5-6 factors (including factor 1) 75%: 3-4 factors (including factor 1) 50%: 2 factors (including factor 1) 25% Factor 1 (not just any 1 factor) 0%: 0 factors (or does not meet factor 1)	• PCMH 2011 Element A, factor 4 aligns with PCMH 2014 Element B, factor 4, with these differences: *PCMH 2011*: Evaluates documentation of clinical advice in patient medical record when office is open. – *PCMH 2014:* Evaluates documentation of clinical advice 24/7. • *New factors:* PCMH 2014 factors 3-6.
CRITICAL FACTOR = FACTOR 2 **Element 1B: After-Hours Access** ***4 points*** The practice has a written process and defined standards and demonstrates that it monitors performance against the standards for: 1. Providing access to routine and urgent-care appointments outside regular business hours 2. Providing continuity of medical record information for care and advice when office is not open 3. Providing timely clinical advice by telephone when the office is not open 4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open 5. Documenting after-hours clinical advice in patient records	**CRITICAL FACTOR = FACTOR 2** **Element 1B: 24/7 Access to Clinical Advice** ***3.5 points*** The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on: 1. Providing continuity of medical record information for care and advice when the office is closed 2. Providing timely clinical advice by telephone 3. Providing timely clinical advice using a secure, interactive electronic system 4. Documenting clinical advice in patient records **Documentation** • *Factors 1–4:* Dated documented process for arranging after-hours access, making medical records available	• *General:* Factors in PCMH 2011, Elements A and B have been separated into categories more specific to their focus in PCMH 2014 Elements A and B. • PCMH 2011 Element B, factor 1 aligns with PCMH 2014 Element A, factor 2. • PCMH 2011 Element B, factor 2 aligns with PCMH 2014 Element B, factor 1. • PCMH 2011 Element B, factor 3 aligns with PCMH 2014 Element B, factor 2, with these differences: *PCMH 2011*: Evaluates advice by telephone when office is not open. *PCMH 2014:* Evaluates advice by telephone 24/7. • PCMH 2011 Element B, factor 4 aligns with PCMH 2014 Element B, factor 3, with these differences: *PCMH 2011*: Evaluates advice by secure interactive electronic system when office is not open.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Documentation • *Factors 1-5:* Documented process for arranging after-hours access, making medical records available after hours, providing timely advice after hours, documenting advice after hours. • *Factor 1:* Report showing after-hours availability or materials with after-hours care. • *Factors 3,4:* Report showing after-hours calls/e-mails, response times. • *Factor 5:* Three examples of clinical advice or report with percentage of documented advice in record in a recent 1-month period. **Scoring** 100%: 5 factors 75%: 4 factors (including factor 3) 50%: 3 factors (including factor 3) 25% 1-2 factors 0%: 0 factors	after hours, providing timely advice after hours, documenting advice after hours and • *Factors 2,3*: Report with at least 7 calendar days of data showing after hours calls/emails, response times. • *Factor 4*: Three examples of clinical advice or report with percent documented advice in record. **Scoring** 100%: 4 factors (including factor 2) 75%: 3 factors (including factor 2) 50%: 2 factors (including factor 2) 25% 1 factor (or does not meet factor 2) 0%: 0 factors (or does not meet factor 2)	*PCMH 2014:* Evaluates advice by secure interactive electronic system 24/7. • PCMH 2011 Element B, factor 5 aligns with PCMH 2014 Element B, factor 4, with these differences: *PCMH 2011*: Evaluates documentation of clinical advice in patient medical record when office is not open. *PCMH 2014:* Evaluates documentation of clinical advice 24/7.
Element 1C: Electronic Access ***2 points*** The practice provides the following information and services to patients and families through a secure electronic system. 1. More than 50 percent of patients who request an electronic copy of their health information (e.g., problem lists, diagnoses, diagnostic test results, medication lists and allergies) receive it within three business days+ 2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists and allergies) within four business days of when the information is available to the practice++ 3. Clinical summaries are provided to patients for >50 percent of office visits within three business days+ 4. Two-way communication between patients/families and the practice 5. Request for appointments or prescription refills	**Element 1C: Electronic Access** ***2 points*** The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system. 1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+ 2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+ 3. Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits 4. A secure message was sent by more than 5 percent of patients+ 5. Patients have two-way communication with the practice 6. Patients can request appointments, prescription refills, referrals and test results	• *General:* Expands PCMH 2014 Element C to include caregivers. • PCMH 2011 factor 1 has no PCMH 2014 equivalent. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 1, with these differences: *PCMH 2011*: Evaluates that at least 10 percent of patients have electronic access to their health information. *PCMH 2014:* Evaluates that more than 50 percent of patients have online access to their health information. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 3, with these differences: *PCMH 2011*: Evaluates that clinical summaries are provided to patients for more than 50 percent of office visits within 3 business days.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
6. Request for referrals or test results **Documentation** • *Factors 1-3:* Report showing percentage of patients who received electronic copy of health information, access to requested health information, electronic clinical summaries. (NA for factor 1 if no requests in reported time period). • *Factors 4-6:* Screen shots of its secure Web site or portal, Web page where patients can make requests and communication capability with patients. **Scoring** 100%: 5-6 factors 75%: 3-4 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	+ Meaningful Use Modified Stage 2 Alignment **Documentation** • *Factors 1-4:* Report based on numerator and denominator for at least 3 months of data in the electronic system. • *Factors 5 and 6:* Screen shots showing the capability of the practice's system. **Scoring** 100%: 5-6 factors 75%: 3-4 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	*PCMH 2014:* Evaluates that clinical summaries are provided for more than 50 percent of office visits within 1 business day. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 5. • PCMH 2011 factors 5 and 6 have been merged into PCMH 2014 factor 6. *PCMH 2011*: Evaluates that patients can request appointments or prescription refills (factor 5) and referrals or test results (factor 6) through a secure electronic system. *PCMH 2014:* Evaluates that patients can request appointments, prescription refills, referrals and test results through a secure electronic system. • *New factors:* PCMH 2014 factor 2 PCMH 2014 factor 4
	PCMH 2: Team-Based Care The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches. ***12 points***	
Element 1D: Continuity ***2 points*** The practice provides continuity of care for patients/families by: 1. Expecting patients/families to select a personal clinician 2. Documenting the patient's/family's choice of clinician 3. Monitoring the percentage of patient visits with selected clinician or team **Documentation** • *Factor 1:* Documented process or materials for clinician selection. • *Factor 2:* Screen shot showing patient choice of clinician.	**Element 2A: Continuity** ***3 points*** The practice provides continuity of care for patients/families by: 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team 3. Having a process to orient new patients to the practice 4. Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care	• PCMH 2011 factors 1 and 2 have been merged into PCMH 2014 factor 1, with these differences: *PCMH 2011*: Evaluates that the practice expect patient/families to select a personal clinician. *PCMH 2014*: Evaluates that the practice assists patients/families when selecting a personal clinician. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 2. • PCMH 2011 Element 5C, factor 6 aligns with PCMH 2014 Element 2A, factor 4. • *New factor:* PCMH 2014 factor 3.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factor 3:* Report showing patient encounters with designated clinician or team (minimum 1 week of data or equivalent). **Scoring** 100%: 3 factors 50%: 2 factors 75%: No scoring option 25%: 1 factor 0%: 0 factors Solo practitioners may mark "yes" for all factors and indicate that they are the sole personal clinician for the practice in the **Comments** field, for full credit.	**Documentation** • *Factor 1:* Dated documented process for clinician selection and example showing patient's choice of clinician on record. • *Factor 2:* Report with at least 5 days of data showing patient encounters with the personal clinician. • *Factor 3:* Dated documented process outlining the process to orient patients to the practice. • *Factor 4:* For pediatric practices, an example of a written transition care plan; for family medicine practices a dated documented process and materials for outreach; for internal medicine practices a dated documented process. **Scoring** 100%: 3-4 factors 75%: No scoring option 50%: 2 factors 25% 1 factor 0%: 0 factors Solo practitioners may mark yes for factors 1 and 2 and indicate that they are the sole personal clinician for the practice in the Support Text/Notes box in the Survey Tool.	
Element 1E: Medical Home Responsibilities ***2 points*** The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following. 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside of the practice	**Element 2B: Medical Home Responsibilities** ***2.5 points*** The practice has a process for informing patients/ families about the role of the medical home and gives patients/families materials that contain the following information: 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice	• PCMH 2011 factors 1-3 aligns with PCMH 2014 factors 1-3. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 4, with these differences: *PCMH 2011*: Evaluates that the care team provides the patient/family with access to evidence based care and self-management. *PCMH 2014:* Evaluates that the practice informs patients that the care team provides access to evidence-based care, patient/family education and self-management support. • *New factors:* PCMH 2014 factors 5-8.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
4. The care team provides the patient/family with access to evidence-based care and self-management support **Documentation** • *Factors 1-4:* Documented process for providing information to patients. • *Factors 1-4:* Patient materials. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	4. The care team provides access to evidence-based care, patient/family education and self-management support 5. The scope of services available within the practice including how behavioral health needs are addressed 6. The practice provides equal access to all of their patients regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage 8. Instructions on transferring records to the practice, including a point of contact at the practice **Documentation** • *Factors 1-8:* Dated documented process for providing information to patients and • *Factors 1-8:* Patient materials. **Scoring** 100%: 7-8 factors 75%: 5-6 factors 50%: 3-4 factors 25% 1-2 factors 0%: 0 factors	
Element 1F: Culturally and Linguistically Appropriate Services (CLAS) ***2 points*** The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/ families. 1. Assessing the racial and ethnic diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population **Documentation** • *Factors 1-4:* Documented process for providing information to patients.	**Element 2C: Culturally and Linguistically Appropriate Services** ***2.5 points*** The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population **Documentation** • *Factors 1 and 2:* Report showing the practices assessment of racial, ethnic, at least one other	• PCMH 2011 factor 1 aligns with PCMH 2014 factor 1, with these differences: *PCMH 2011*: Assesses racial and ethnic diversity of its population. *PCMH 2014:* Assesses an expanded definition of diversity (which includes race and ethnicity) of its population. • PCMH 2011 factors 2-4 aligns with PCMH 2014 factors 2-4.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factors 1-4:* Patient materials. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	meaningful characteristic of diversity, and language composition of its patient population. • *Factor 3:* Dated documented process for providing bilingual services. • *Factor 4:* Patient materials. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	
CRITICAL FACTOR = FACTOR 2 **Element 1G: The Practice Team** ***4 points*** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Having regular team meetings or a structured communication process 3. Using standing orders for services 4. Training and assigning care teams to coordinate care for individual patients 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills 8. Involving care team staff in the practice's performance evaluation and quality improvement activities **Documentation** • *Factors 1, 4-7:* Description of staff positions or responsibilities. • *Factor 2:* Description of staff communication processes and sample. • *Factor 3:* Written standing orders.	**MUST-PASS** **CRITICAL FACTOR = FACTOR 3** **Element 2D: The Practice Team** ***4 points*** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities	• PCMH 2011 factor 1 aligns with PCMH 2014 factor 1. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 3, with this difference: *PCMH 2014*: Specifies that regular patient care team meetings or structured communication process is focused on individual patient care. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 4. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 5. • PCMH 2011 factor 5 aligns with PCMH 2014 factor 6, with this difference: *PCMH 2014:* Expands PCMH 2014 factor to include caregivers. • PCMH 2011 factors 6 aligns with PCMH 2014 factors 7. • PCMH 2011 factor 7 has been merged into the requirements for communication throughout this element • PCMH 2011 factors 8 aligns with PCMH 2014 factors 9. • PCMH 2014 factor 10 aligns with PCMH 2011 Element 6C, factor 4. • *New factors:*

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factors 4-7:* Description of training process, schedule, materials. • *Factor 8:* Description of staff role in practice improvement process or minutes demonstrating staff involvement. **Scoring** 100%: 7-8 factors (including factor 2) 75%: 5-6 factors (including factor 2) 50%: 4 factors (including factor 2) 25% 2-3 factors 0%: 0 factors	10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council **Documentation** • *Factors 1,5,6,7:* Staff position descriptions or responsibilities and • *Factor 2: Overview of staffing structure for team-based care* • *Factor 3:* Description of staff communication processes and at least three examples • *Factor 4:* At least one example of written standing orders • *Factors 5-7:* Description of training process and schedule, or materials showing how staff are trained. • *Factor 8:* Description of staff communication processes and at least one example • *Factor 9:* Dated documented process for quality improvement. • *Factor 10:* Dated documented process demonstrating how it involves patients/families in QI teams or advisory council **Scoring** 100%: 10 factors (including factor 3) 75%: 8-9 factors (including factor 3) 50%: 5-7 factors (including factor 3) 25% 2-4 factors (or does not meet factor 3) 0%: 0-1 factors (or does not meet factor 3)	PCMH 2014 factor 2. PCMH 2014 factor 8.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
PCMH 2: Identify and Manage Patient Populations The practice systematically records patient information and uses it for population management to support patient care. ***16 points***	**PCMH 3: Population Health Management** The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population. **20 points**	
Element 2A: Patient Information ***3 points*** The practice uses an electronic system that records the following as structured (searchable) data for >50% of the patients. 1. Date of birth+ 2. Gender+ 3. Race+ 4. Ethnicity+ 5. Preferred language+ 6. Telephone numbers 7. E-mail address 8. Dates of previous clinical visits 9. Legal guardian/health care proxy 10. Primary caregiver 11. Presence of advance directives (NA for pediatric practices) 12. Health insurance information **Documentation** • *Factors 1-12:* Report from electronic system showing the percentage of all patients for each populated data field. The report contains each required data item to determine how many factors are entered consistently (numerator and denominator showing >50%) for a 12-month (or 3 months of data) sample of patients. **Scoring** 100%: 9-12 factors 75%: 7-8 factors 50%: 5-6 factors 25% 3-4 factors 0%: 0-2 factors	**Element 3A: Patient Information** ***3 points*** The practice uses an electronic system to records patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients: 1. Date of birth 2. Sex 3. Race 4. Ethnicity 5. Preferred language 6. Telephone numbers 7. E-mail address 8. Occupation (NA for pediatric practices) 9. Dates of previous clinical visits 10. Legal guardian/health care proxy 11. Primary caregiver 12. Presence of advance directives (NA for pediatric practices) 13. Health insurance information 14. Name and contact information of other health care professionals involved in patient's care **Documentation** • *Factors 1-13:* Report with numerator and denominator with at least 3 months of data. • Factor 14 does not need to be captured in structured data fields. NCQA reviews: The practice's documented process for capturing the data Three examples demonstrating implementation of the process.	• *General:* *PCMH 2011:* Assesses that practices have data for >50% of patients. *PCMH 2014:* Assesses that practices have data for >80% of patients. • PCMH 2011 factor 1 aligns with PCMH 2014 factor 1. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 2, with these differences: *PCMH 2011:* Evaluates patient gender. *PCMH 2014:* Evaluates patient sex. • PCMH 2011 factors 3–7 align with PCMH 2014 factors 3–7. • PCMH 2011 factor 8 aligns with PCMH 2014 factor 9. • PCMH 2011 factor 9 aligns with PCMH 2014 factor 10. • PCMH 2011 factor 10 aligns with PCMH 2014 factor 11. • PCMH 2011 factor 11 aligns with PCMH 2014 factor 12. • PCMH 2011 factor 12 aligns with PCMH 2014 factor 13. • *New factors:* PCMH 2014 factor 8. PCMH 2014 factor 14.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
	Scoring 100%: 10-14 factors 75%: 8-9 factors 50%: 5-7 factors 25% 3-4 factors 0%: 0-2 factors	
Element 2B: Clinical Data ***4 points*** The practice uses an electronic system to record the following as structured (searchable) data. 1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients+ 2. Allergies, including medication allergies and adverse reactions* for more than 80 percent of patients+ 3. Blood pressure, with the date of update for >50% of patients 2 years and older+ 4. Height for >50% of patients 2 years and older+ 5. Weight for >50% of patients 2 years and older+ 6. System calculates and displays BMI (NA for pediatric practices)+ 7. System plots and displays growth charts (length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (NA for adult practices)+ 8. Status of tobacco use for patients 13 years and older for >50% of patients+ 9. List of prescription medications with date of updates for more than 80 percent of patients+ **Documentation** • *Factors 1-5, 8, 9:* Report showing percentage of patients for each data field. • *Factors 6-7:* Screen shots demonstrating BMI/BMI percentile capability of electronic system. • *Factors 6-8:* May respond NA, with explanation of patient age range.	**Element 3B: Clinical Data** ***4 points*** The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data. 1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients 2. Allergies, including medication allergies and adverse reactions for more than 80 percent of patients 3. Blood pressure, with the date of update for more than 80 percent of patients 3 years and older 4. Height/length for more than 80 percent of patients 5. Weight for more than 80 percent of patients 6. System calculates and displays BMI 7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices) 8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients 9. List of prescription medications with date of updates for more than 80 percent of patients 10. More than 20 percent of patients have family history recorded as structured data 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 **Documentation** • *Factors 1-5, 8-11:* Reports with a numerator and denominator. • *Factors 6, 7:* Screen shots demonstrating capability.	• PCMH 2011 factors 1 and 2 align with PCMH 2014 factor 1 and 2. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 3, with these differences: *PCMH 2011:* Evaluates blood pressure for patients 2 years and older and whether practices have data for >50% of patients. *PCMH 2014:* Evaluates blood pressure for patients 3 years and older and whether practices have data for >80% of patients. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 4, with these differences: *PCMH 2011:* Evaluates "height" and how practices record height for patients 2 years and older, and whether practices have data for >50% of patients. *PCMH 2014:* Evaluates "height/length" and has no age component, and evaluates that records contain height for >80 percent of patients. • PCMH 2011 factor 5 aligns with PCMH 2014 factor 5, with these differences: *PCMH 2011:* Evaluates how practices record weight for patients 2 years and older and whether practices have data for >50% of patients. *PCMH 2014:* Has no age component for weight and evaluates whether records contain weight for >80% of patients. • PCMH 2011 factor 6 aligns with PCMH 2014 factor 6.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Scoring 100%: 9 factors 75%: 7-8 factors 50%: 5-6 factors 25% 3-4 factors 75%: 0-2 factors	**Scoring** 100%: 9-11 factors 75%: 7-8 factors 50%: 5-6 factors 25% 3-4 factors 0%: 0-2 factors	• PCMH 2011 factor 7 aligns with PCMH 2014 factor 7, with these differences: *PCMH 2011:* Specifies head circumference for patients <2 years and evaluates BMI percentile for patients 2-20 years. *PCMH 2014:* Has no age specification for head circumference and evaluates length/height, weight and head circumference and BMI percentile for patients 0-20 years. • PCMH 2011 factor 8 aligns with PCMH 2014 factor 8, with these differences: *PCMH 2011:* Evaluates status of tobacco use in the records for >50% of patients. *PCMH 2014:* Evaluates status of tobacco use in the records for >80% of patients. • PCMH 2011 factor 9 aligns with PCMH 2014 factor 9. • *New factors:* PCMH 2014 factor 10.PCMH 2014 factor 11.
Element 2C: Comprehensive Health Assessment ***4 points*** To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: 1. **Documentation** of age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Patient and family mental health/substance abuse 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) 9. Depression screening for adults and adolescents using a standardized tool	**Element 3C: Comprehensive Health Assessment** ***4 points*** To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes: 1. Age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Mental health/substance use history of patient and family 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients)	• *General:* *PCMH 2011:* Evaluates whether practices collect and document a comprehensive health assessment. *PCMH 2014:* Evaluates whether practices collect and regularly update a comprehensive health assessment. • PCMH 2011 factors 1-6 align with PCMH 2014 factors 1-6. • PCMH 2011 factor 7 aligns with PCMH 2014 factor 7, with these differences: *PCMH 2011:* Evaluates that practices document patient and family mental health/substance abuse. *PCMH 2014:* Evaluates that practices document of patient and family mental health/substance use history.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Documentation *Factors 1-9:* Process showing how information is collected or a completed patient assessment (de-identified). **Scoring** 100%: 8-9 factors 75%: 6-7 factors 50%: 4-5 factors 25% 2-3 factors 0%: 0-1 factors	9. Depression screening for adults and adolescents using a standardized tool 10. Assessment of health literacy **Documentation** • *Factors 1-10:* Documentation requires the practice to provide practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor. The report must indicate that data was entered in the medical record for more than 50 percent in order for the practice to respond "yes" to each factor in the survey tool ***OR*** review the patient records selected for the medical record review as required in elements 4B and 4C and document presence or absence in the Record Review Workbook (RRWB). If using the RRWB, examples are required. • *Factors 8,9:* In addition to the report described above, the practice must provide a completed form (de-identified) for each factor. **Scoring** 100%: 8-10 factors 75%: 6-7 factors 50%: 4-5 factors 25% 2-3 factors 0%: 0-1 factors	• PCMH 2011 factor 8 and 9 aligns with PCMH 2014 factor 8 and 9. • *New factor:* PCMH 2014 factor 10.
MUST-PASS **Element 2D: Use Data for Population Management 5 *points*** The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/families and clinicians of services needed for: 1. At least three different preventive care services++ 2. At least three different chronic or acute care services++ 3. Patients not recently seen by the practice	**MUST-PASS** **Element 3D: Use Data for Population Management5 *points*** 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: 1. At least two different preventive care services 2. At least two different immunizations 3. At least three different chronic or acute care services	• *General:* *PCMH 2011:* Evaluates whether practices uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/families and clinicians of services needed. *PCMH 2014:* Evaluates whether practices proactively identifies populations of patients and reminds patients/families/caregivers of needed care based on patient information, clinical data, health assessments and evidence-based guidelines.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
4. Specific medications **Documentation** • *Factors 1-4:* Lists or summary reports of patients who need services within past 12 months. (Health plan data is acceptable if it represents 75% of the patient population.) Must include at least 3 different immunizations/screenings and 3 different acute/chronic care services. • *Factors 1-4:* Materials demonstrating patient notification (letter, phone call script, screen shot of e-notice). **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	4. Patients not recently seen by the practice 5. Medication monitoring or alert **Documentation** • *Factors 1-5:* Lists or summary reports of patients who need services within past 12 mo. (Health plan data okay if 75% of patient population) and • *Factors 1-5:* Materials showing how patients were notified for each service. The practice must perform these functions at least annually and make documentation of each reminder available to NCQA upon request. **Scoring** 100%: 4-5 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	• PCMH 2011 factor 1 aligns with PCMH 2014 factor 1, with these differences: *PCMH 2011:* Evaluates whether practices generate lists of patients and remind patients for at least 3 different preventive services. *PCMH 2014:* Evaluates whether practices generate lists of patients and remind patients for at least 2 different preventive services. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 3. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 4. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 5, with these differences: *PCMH 2011:* Evaluates whether practices generate lists of patients and remind patients for specific medications. *PCMH 2014:* Evaluates whether practices generate lists of patients and remind patients for medication monitoring or alert. • *New factor:* PCMH 2014 factor 2.
PCMH 3: Plan and Manage Care The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines. ***17 points***		
CRITICAL FACTOR = FACTOR 3 **Element 3A: Implement Evidence-Based Guidelines** ***4 points*** The practice implements evidence-based guidelines through point of care reminders for patients with: 1. The first important condition+ 2. The second important condition+ 3. The third condition, related to unhealthy behaviors or mental health or substance abuse	**CRITICAL FACTOR = FACTOR 1** **Element 3E: Implement Evidence-Based Decision Support** ***4 points*** The practice implements clinical decision support + (e.g. point-of-care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder+ 2. A chronic medical condition+ 3. An acute condition+	• *General:* *PCMH 2011:* Evaluates whether practices implements evidence-based guidelines through point of care reminders. *PCMH 2014:* Evaluates whether practices implements clinical decision support following evidence-based guidelines. • PCMH 2011 factors 1 and 2 have no PCMH 2014 equivalent.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Documentation • *Factors 1-3:* Identification of 3 conditions. • *Factors 1-3:* Name and source of guidelines. • *Factors 1-3:* Demonstrate how guidelines are used (e.g. charting tools, screen shots, workflow organizers, condition-specific templates for treatment plans/patient progress). **Scoring** 100%: 3 factors 75%: No scoring option 50%: 2 factors (including factor 3) 25% 1 factor 0%: 0 factors	4. A condition related to unhealthy behaviors+ 5. Well child or adult care+ 6. Overuse/appropriateness issues+ + Meaningful Use Modified Stage 2 Alignment **Documentation** • *Factors 1-6:* Provide conditions that the practice identified for each factor, the source of guidelines used for each condition and examples that demonstrate how guidelines are implemented (e.g. charting tools, screen shots, workflow organizers, condition-specific templates for treatment plans/patient progress monitoring). **Scoring** 100%: 5-6 factors (including factor 1) 75%: 4 factors (including factor 1) 50%: 3 factors 25% 1-2 factors 0%: 0 factors	• PCMH 2011 factor 3 has been split into PCMH 2014 factors 1 and 4. • *New factors:* PCMH 2014 factor 2. PCMH 2014 factor 3. PCMH 2014 factor 5. PCMH 2014 factor 6.
	PCMH 4: Care Management and Support The practice systematically identifies individual patients and plans, manages and coordinates care, based on need. ***20 points***	
Element 3B: Identify High- Risk Patients ***3 points*** To identify high-risk or complex patients the practice: 1. Establishes criteria and a systematic process to identify high-risk or complex patients 2. Determines the percentage of high-risk or complex patients in its population **Documentation** • *Factor 1:* Criteria and process to identify patients. • *Factor 2:* Report showing number and percentage of high-risk patients.	**CRITICAL FACTOR = FACTOR 6** **Element 4A: Identify Patients for Care Management** ***4 points*** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver	• *General:* *PCMH 2011:* Evaluates whether practices identify high-risk or complex patients. *PCMH 2014:* Evaluates whether practices identify patients who may benefit from care management. • PCMH 2011 factor 1 aligns with PCMH 2014 Element A stem, with these differences: *PCMH 2011:* Evaluates whether practices establish criteria and a systematic process to identify high-risk or complex patients.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Scoring 100%: 2 factors 25% 1 factor 75%: No scoring option 50%: No scoring option 0%: 0 factors	6. The practice monitors the percentage of the total patient population identified through its process and criteria **Documentation** • *Factors 1-5*: Criteria and process for identifying patients. • *Factor 6:* Report showing number and percentage of patients identified as likely to benefit from care management through one or any combination of the other five factors or other criteria determined by the practice. **Scoring** 100%: 5-6 factors (including factor 6) 75%: 4 factors (including factor 6) 50%: 3 factors (including factor 6) 25% 2 factors (including factor 6) 0%: 0-1 factors (or does not meet factor 6)	*PCMH 2014:* Evaluates whether practices establish criteria and a systematic process to identify patients who may benefit from care management and evaluates practices consideration of 6 factors in their process. • PCMH 2011 factor 2 has no PCMH 2014 equivalent. • *New factors:* PCMH 2014 factors 1-6.
MUST-PASS **Element 3C: Care Management** ***4 points*** The care team performs the following for at least 75 percent of the patients for the patients identified in Elements A and B: 1. Conducts pre-visit preparations 2. Collaborates with the patient/family to develop an individualized care plan, including treatment goals that are reviewed and updated at each relevant visit 3. Gives the patient/family a written plan of care 4. Assesses and addresses barriers when patient has not met treatment goals 5. Provides patient/family a clinical summary at each relevant visit 6. Identifies patients/families who might benefit from additional care management support 7. Follows up with patients/families who have not kept important appointments	**MUST-PASS** **Element 4B: Care Planning and Self-Care Support** ***4 points*** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A: 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/ caregiver **Documentation** • *Factors 1-5:* Report from electronic system or submission of Record Review Workbook. If using the Record Review Workbook, examples are required demonstrating how each factor is documented.	• PCMH 2011 factor 1 has no PCMH 2014 equivalent. • PCMH 2011 Element C stem and factor 2 have merged into PCMH 2014 Element B stem, with this differences: *PCMH 2014:* Stem expanded to include caregivers. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 5. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 3, with these differences: *PCMH 2011:* Evaluates whether practices assess and address barriers when patient has not met treatment goals. *PCMH 2014:* Evaluates whether practices assess and address potential barriers to meeting goals. • PCMH 2011 factor 5 has no PCMH 2014 equivalent.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Documentation *Factors 1-7:* Report from electronic system or submission of Record Review Workbook. **Scoring** 75% of patients for each factor 100%: 6-7 factors 75%: 5 factors 50%: 3-4 factors 25% 1-2 factors 0%: 0 factors	**Scoring** 75% of patients for each factor 100%: 5 factors 75%: 4 factors 50%: 3 factors 25% 1-2 factors 0%: 0 factors	• PCMH 2011 factor 6 has no PCMH 2014 equivalent. • PCMH 2011 factor 7 has no PCMH 2014 equivalent. • *New factors:* PCMH 2014 factor 1. PCMH 2014 factor 2. PCMH 2014 factor 4.
CRITICAL FACTOR = FACTOR 1 **Element 3D: Medication Management** ***3 points*** The practice manages medications in the following ways. 1. Reviews and reconciles medications with patients/ families for >50% of care transitions++ 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions 3. Provides information about new prescriptions to more than 80 percent of patients/families 4. Assesses patient/family understanding of medications for >50% of patients with date of assessment 5. Assesses patient response to medications and barriers to adherence for >50% of patients with date of assessment 6. Documents over-the-counter medications, herbal therapies and supplements for >50% of patients/ families with the date of updates. **Documentation** • *Factors 1-6:* Report from electronic system or submission of Record Review Workbook.	**CRITICAL FACTOR = FACTOR 1** **Element 4C: Medication Management** ***4 points*** The practice has a process for managing medications, and systematically implements the process in the following ways: 1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions+ 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions 3. Provides information about new prescriptions to more than 80 percent of patients/families/ caregivers. 4. Assesses understanding of medications for more than 50 percent of patients/families/ caregivers, and dates the assessment 5. Assesses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment 6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates + Meaningful Use Modified Stage 2 Alignment	• *General:* *PCMH 2011:* Evaluates whether practices manage medications. *PCMH 2014:* Evaluates whether practices have a process and demonstrates that it systematically manages medications. • PCMH 2011 factors 1 and 2 align with PCMH 2014 factors 1 and 2. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 3, with this difference: *PCMH 2014:* Expands factor to include caregivers. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 4, with this difference: *PCMH 2014:* Expands factor to include caregivers. • PCMH 2011 factors 5 and 6 align with PCMH 2014 factors 5 and 6.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Scoring 100%: 5-6 factors (including factor 1) 75%: 3-4 factors (including factor 1) 50%: 2 factors (including factor 1) 25% Factor 1 0%: 0 factors or does not meet factor 1	**Documentation** • *Factors 1-6:* Report from electronic system or submission of Record Review Workbook. If using the Record Review Workbook, examples are required demonstrating how each factor is documented. **Scoring** 100%: 5-6 factors (including factor 1) 75%: 3-4 factors (including factor 1) 50%: 2 factors (including factor 1) 25% 1 factor (including factor 1) 0%: 0 factors (or does not meet factor 1)	
CRITICAL FACTOR = FACTOR 2 **Element 3E: Use Electronic Prescribing** ***3 points*** The practice uses an electronic prescription system with the following capabilities. 1. Generates and transmits at least 40 percent of eligible prescriptions to pharmacies+ 2. Generates at least 75 percent of eligible prescriptions 3. Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list+ 4. Performs patient-specific checks for drug-drug and drug-allergy interactions+ 5. Alerts prescriber to generic alternatives 6. Alerts prescriber to formulary status++ **Documentation** • *Factors 1-3:* Reports showing percent of electronic prescriptions generated, transmitted and entered into medical record. • *Factor 2 alternative:* Prescribing process, report, explanation. • *Factors 4-6:* Reports or screen shots demonstrating the system's capabilities.	**Element 4D: Use Electronic Prescribing** **3 *points*** The practice uses an electronic prescription system with the following capabilities. 1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies+ 2. Enters electronic medication orders in the medical record for more than 60 percent of medications+ 3. Performs patient-specific checks for drug-drug and drug-allergy interactions+ 4. Alerts prescriber to generic alternatives + Meaningful Use Modified Stage 2 Alignment **Documentation** • *Factor 1:* Screenshot displaying the formulary decision support mechanism used. • *Factors 1, 2:* Report with a numerator and denominator. • *Factors 3, 4:* Report with numerator and denominator **or** screen shots demonstrating the system's capabilities.	• PCMH 2011 factors 1 and 6 have merged with PCMH 2014 factor 1, with this difference: *PCMH 2014:* Evaluates whether practices compare prescriptions with drug formularies *and* send >50% to pharmacies electronically. • PCMH 2011 factor 2 has no PCMH 2014 equivalent. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 2, with these differences: *PCMH:* Evaluates whether electronic medical orders are entered for <30% of patients. *PCMH 2014:* Evaluates whether electronic medical orders are entered for >60% of patients. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 3. • PCMH 2011 factor 5 aligns with PCMH 2014 factor 4.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Scoring 100%: 5-6 factors (including factor 2) 75%: 4 factors (including factor 2) 50%: 2-3 factors (including factor 2) 25% 1 factor 0%: 0 factors	**Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	
PCMH 4: Provide Self-Care Support and Community Resources The practice acts to improve patients' ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support. ***9 points***		
MUST-PASS **CRITICAL FACTOR = FACTOR 3** **Element 4A: Support Self-Care Process** ***6 points*** The practice conducts activities to support patients/ families in self-management: 1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to assist in self-management 2. Uses an EHR to identify patient-specific education resources and provide to more than 10 percent of patients, if appropriate++ 3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families 4. Documents self-management abilities for at least 50 percent of patients/families 5. Provides self-management tools to record self-care results for at least 50 percent of patients/families 6. Counsels at least 50 percent of patients/families to adopt healthy behaviors **Documentation** • *Factors 1-6:* Report from electronic system or submission of Record Review Workbook.	**Element 4E: Support Self-Care and Shared Decision Making** **5 *points*** The practice has, and demonstrates use of, materials to support patients and families/ caregivers in self-management and shared decision making. The practice: 1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+ 2. Provides educational materials and resources to patients 3. Provides self-management tools to record self-care results 4. Adopts shared decision making aids 5. Offers or refers patients to structured health education programs such as group classes and peer support 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources. + Meaningful Use Modified Stage 2 Alignment	• *General:* *PCMH 2011:* Stem evaluates whether practices conduct activities to support patient/families in self-management. *PCMH 2014:* Stem expands to include caregivers and evaluates whether practices has and demonstrates use of materials to support patient and families/caregivers in self-management and shared decision making. • PCMH 2011 factor 1 has been split into PCMH 2014 factors 2 and 5, with these differences: *PCMH:* Evaluates whether educational resources are provided or >50% of patient/families are referred to educational resources. *PCMH 2014:* Evaluates whether educational materials *and* resources are provided *and* patients are offered or referred to structured health education programs. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 1, with this difference: *PCMH 2014:* Deletes 'if applicable.' • PCMH 2011 factor 3 has no PCMH 2014 equivalent.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Scoring 100%: 5-6 factors (including factor 3) 75%: 4 factors (including factor 3) 50%: 3 factors (including factor 3) 25% 1-2 factors 0%: 0 factors	**Documentation** • *Factor 1:* Report showing percentage of patients provided educational resources. • *Factors 2-5:* For each factor, at least three examples resources, tools or aids. • *Factor 6:* Materials demonstrating that the practice offers at least five resources. • *Factor 7:* Survey or materials showing how the practice collects information on the usefulness of referrals to community resources. **Scoring** 100%: 5-7 factors 75%: 4 factors 50%: 3 factors 25% 1-2 factors 0%: 0 factors	• PCMH 2011 factor 4 has no PCMH 2014 equivalent. • PCMH 2011 factor 5 aligns with PCMH 2014 factor 3. • PCMH 2011 factor 6 has no PCMH 2014 equivalent. • *New factors:* PCMH 2014 factor 4. PCMH 2014 factor 7.
Element 4B: Provide Referrals to Community Resources ***3 points*** The practice supports patients/families that need access to community resources: 1. Maintains a current resource list on five topics or key community service of importance to practice population 2. Tracks referrals provided to patients/families 3. Arranges or provides treatment for mental health and substance abuse disorders 4. Offers opportunities for health educational programs (such as group classes and peer support) **Documentation** • *Factor 1:* List of community services or agencies. • *Factor 2:* Referral log or report covering at least 1 month. • *Factors 3-4:* Processes to provide/arrange for mental health/substance abuse treatment and health education support. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors		• PCMH 2011 Element B, factor 1 aligns with PCMH 2014 Element E, factor 6, with this difference: *PCMH 2014:* Expanded to include services offered outside the practice and its affiliates. • PCMH 2011 factors 2 and 3 has no PCMH 2014 equivalent. • PCMH 2011 Element B, factor 4 aligns with PCMH 2014 Element E, factor 5, with these differences: *PCMH 2011:* Evaluates whether opportunities for health educational programs are offered. *PCMH 2014:* Evaluates whether structured health education programs are offered or referred.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
PCMH 5: Track and Coordinate Care The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations. ***18 points***	**PCMH 5: Care Coordination and Care Transitions** The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations. ***18 points***	
CRITICAL FACTORS = FACTORS 1 AND 2 **Element 5A: Test Tracking and Follow-Up *6 points*** The practice has a documented process for and demonstrates that it: 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows-up with inpatient facility on newborn hearing and newborn blood-spot screening (NA for adults) 7. Electronically communicates with labs to order tests and retrieve results 8. Electronically communicates with facilities to order and retrieve imaging results 9. Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in the medical record++ 10. Electronically incorporates imaging test results into in the medical record **Documentation** • *Factors 1-6:* Process/procedure for staff. • *Factors 1, 2:* Report, log or evidence of process use • Report must include a minimum of 1 week of data or the equivalent. • *Factors 3-6:* Examples showing factors are met. • *Factor 6:* Provide a written explanation for NA.	**CRITICAL FACTORS = FACTORS 1 AND 2** **Element 5A: Test Tracking and Follow-Up 6 *points*** The practice has a documented process for and demonstrates that it: 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults) 7. More than 30 percent of laboratory orders are electronically recorded in the patient record+ 8. More than 30 percent of radiology orders are electronically recorded in the patient record+ 9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record 10. More than 10 percent of scans and tests that result in an image are accessible electronically + Meaningful Use Modified Stage 2 Alignment **Documentation** • *Factors 1-6:* NCQA Reviews: A documented process ***and*** Evidence showing how the process is met for each factor such as a report or log or examples (to	• PCMH 2011 factors 1-6 aligns with PCMH 2014 Element factors 1-6. • PCMH 2011 factor 7 has no PCMH 2014 equivalent. • PCMH 2011 factor 8 has no PCMH 2014 equivalent. • PCMH 2011 factor 9 aligns with PCMH 2014 factor 9, with these differences: *PCMH 2011:* Evaluates whether >40% of all clinical test results are electronically incorporated. *PCMH 2014:* Evaluates whether >55% of all clinical test results are electronically incorporated. • PCMH 2011 factor 10 has no PCMH 2014 equivalent. • *New factors:* PCMH 2014 factor 7. PCMH 2014 factor 8. PCMH 2014 factor 10.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factors 7, 8,10:* Process and examples from electronic system. • *Factor 9:* Report with numerator, denominator and percent; 12 months (3 months, if 12 months not available). ***Note:*** *Both lab and imaging must be included in process and reports in factors 1, 2 to receive a score for this element.* **Scoring** 100%: 8-10 factors (including Factors 1 and 2) 75%: 6-7 factors (including Factors 1 and 2) 50%: 4-5 factors (including Factors 1 and 2) 25% 3 factors (including Factors 1 and 2) 0%: 0-2 factors	receive credit for the factor the practice must show evidence across patients not just a single example). • *Factor 7-10:* Report based on at least three months of data with numerator, denominator and percent. **Scoring** 100%: 8-10 factors (including factors 1 and 2) 75%: 6-7 factors (including factors 1 and 2) 50%: 4-5 factors (including factors 1 and 2) 25% 3 factors (including factors 1 and 2) 0%: 0-2 factors	
MUST-PASS **Element 5B: Referral Tracking and Follow-Up** ***6 points*** The practice coordinates referrals by: 1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information 2. Tracking the status of the referrals, including required timing for receiving a specialist's report 3. Following up to obtain specialist's report 4. Establishing and documenting agreements with specialists in the medical record if co-management is needed 5. Asking patients/families about self-referrals and requesting reports from clinicians 6. Demonstrating capacity for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians+ 7. Providing an electronic summary of care record to another provider for >50% of referrals++ **Documentation** • *Factor 1:* Demonstrate process for important referrals showing reason and clinical information.	**MUST-PASS** **CRITICAL FACTOR = FACTOR 8** **Element 5B: Referral Tracking and Follow-Up** ***6 points*** The practice: 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+	• *General:* *PCMH 2011:* Evaluates whether practices coordinate referrals. *PCMH 2014:* Evaluates whether practices have a documented process and demonstrates certain capabilities. • PCMH 2011 factor 1 has been split into PCMH 2014 factors 5 and 6, with these differences: *PCMH 2011:* Evaluates whether practices give the consultant or specialist the clinical reason for the referral and pertinent clinical information. *PCMH 2014:* Evaluates whether practices give the consultant or specialist the clinical question, the required timing, type of referral (factor 5), pertinent demographic and clinical data, including test results and the current care plan (factor 6). • PCMH 2011 factors 2 and 3 have been merged and aligns with PCMH 2014 factor 8, with these differences: *PCMH 2011:* Evaluates whether practices track the status of the referrals, including required timing and following up to obtain specialist's report.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factors 2-3:* Report or log showing process for tracking, timing and follow up. Report must include a minimum of • 1 week of data or equivalent. • *Factors 4-5:* Documented processes and 3 examples. • *Factor 6:* Screen shot showing capability. • *Factor 7:* Report with numerator, denominator and percent with 12 months (3 months if 12 months not available). **Scoring** 100%: 5-7 factors 75%: 4 factors 50%: 3 factors 25% 1-2 factors 0% 0 factors	8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports 9. Documents co-management arrangements in the patient's medical record 10. Asks patients/families about self-referrals and requesting reports from clinicians + Meaningful Use Modified Stage 2 Alignment **Documentation** • *Factors 1,5,6,8,10:* Dated documented process and at least one example. • *Factor 2,3:* For each factor, the practice provides at least one example. • *Factor 4:* Materials explaining how behavioral health is integrated with physical health. • *Factor 7:* Screen shot showing test of capability ***AND*** report with numerator, denominator and percent; 12 months or 3 months; provide explaination for NA. • *Factor 9:* The practice provides at least 3 examples. **Scoring** 100%: 9-10 factors (including factor 8) 75%: 7-8 factors(including factor 8) 50%: 4-6 factors (including factor 8) 25% 2-3 factors (including factor 8) 0%: 0-1 factors (or does not meet factor 8)	*PCMH 2014:* Evaluates whether practices track referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 9, with these differences: *PCMH 2011:* Evaluates whether practices establish and document agreements with specialists in the medical record if co-management is needed. *PCMH 2014:* Evaluates whether practices document co-management arrangements in the medical record. • PCMH 2011 factor 5 aligns with PCMH 2014 factor 10. • PCMH 2011 factors 6 and 7 have merged and align with PCMH 2014 factor 7. • *New factors:* PCMH 2014 factors 1-4.
Element 5C: Coordinate With Facilities and Care Transitions ***6 points*** On its own or in conjunction with an external organization, the practice systematically: 1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit 2. Demonstrates its process for sharing clinical information with admitting hospitals or emergency departments	**Element 5C: Coordinate Care Transitions** ***6 points*** The practice: 1. Proactively identifies patients with unplanned hospital admissions and emergency department visits 2. Shares clinical information with admitting hospitals and emergency departments 3. Consistently obtains patient discharge summaries from the hospital and other facilities	• *General:* *PCMH 2011:* Evaluates whether practices coordinate with facilities and care transitions on its own or in conjunction with an external organization. *PCMH 2014:* Has no such language in the stem. • PCMH 2011 factor 1 aligns with PCMH 2014 factor 1, with these differences: *PCMH 2011:* Evaluates whether there is a process for identifying patients with a hospital admission and emergency department visits.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities 4. Demonstrates its process for contacting patients/ families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization 6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult-only and family practices) 7. Demonstrates the ability for electronic exchange of key clinical information with facilities 8. Provides an electronic summary-of-care record to another care facility for >50% of transitions of care++ **Documentation** • *Factor 1:* Documented process to identify patients and log or report. • *Factors 2-5:* Documented process and examples of providing clinical information, obtaining discharge summaries, follow up and exchange of information. • *Factor 6:* Example of a written transition care plan. Provide a written explanation for NA. • *Factor 7:* Screen shot showing test of capability. • *Factor 8:* Report with numerator, denominator and percentage of 12 months of transitions (3 months if 12 months not available). Provide a written explanation for NA.	4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Exchanges patient information with the hospital during a patient's hospitalization 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+ + Meaningful Use Modified Stage 2 Alignment **Documentation** • *Factor 1:* Dated documented process to identify patients and log or report. • *Factors 2-6:* Dated documented process. • *Factor 2-4:* For each factor, three examples. • *Factor 5,6:* For each factor, one example. • *Factor 7:* Screen shot showing test of capability ***AND*** report with numerator, denominator and percent; 12 months of transitions, or 3 months if 12 months not available; provide a written explanation for NA. **Scoring** 100%: 7 factors 75%: 5-6 factors 50%: 3-4 factors 25% 1-2 factors 0%: 0 factors	*PCMH 2014:* Evaluates whether there is a process for proactively identifying patients with a hospital admission and emergency department visits both planned and unplanned. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 2. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 3. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 4, with this difference: *PCMH 2014:* Adds 'proactively.' • PCMH 2011 factor 5 aligns with PCMH 2014 factor 5. • PCMH 2011 factor 6 aligns with PCMH 2014 Element 2A, factor 4. • PCMH 2011 factors 7 and 8 have merged into PCMH 2014 factor 7. • *New factor:* PCMH 2014 factor 6.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
PCMH 6: Measure and Improve Performance The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience. ***20 points***	**PCMH 6: Performance Measurement and Quality Improvement** The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience. ***20 points***	
Element 6A: Measure Performance ***4 points*** The practice measures or receives data on the following: 1. At least three preventive care measures 2. At least three chronic or acute care clinical measures 3. At least two utilization measures affecting health care costs 4. Performance data stratified for vulnerable populations (to assess disparities in care) **Documentation** • *Factors 1-4:* Reports showing performance. **Scoring** 100%: 4 factors 75%: 2-3 factors 50%: No scoring option 25% 1 factor 0%: 0 factors	**Element 6A: Measure Clinical Quality Performance** ***3 points*** At least annually, the practice measures or receives data on: 1. At least two immunization measures 2. At least two other preventive care measures 3. At least three chronic or acute care clinical measures 4. Performance data stratified for vulnerable populations (to assess disparities in care). **Documentation** *If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.* • *Factors 1-4:* Reports showing performance. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	• *General:* Factors in PCMH 2011, Element A are reorganized in PCMH 2014, Elements A and B. • PCMH 2011 factor 1 aligns with PCMH 2014 Element A, factors 1 and 2, with these differences: *PCMH 2011:* Evaluates at least three preventive care measures. *PCMH 2014:* Evaluates at least 2 immunization measures (factor 1) and at least two other preventative care measures (factor 2). • PCMH 2011 factor 2 aligns with PCMH 2014 Element A, factor 3. • PCMH 2011 factor 3 aligns with PCMH 2014 Element B, factor 2. • PCMH 2011 factor 4 aligns with PCMH 2014 Element A, factor 4.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
	Element 6B: Measure Resource Use and Care Coordination ***3 points*** At least annually, the practice measures or receives quantitative data on: 1. At least two measures related to care coordination 2. At least two measures affecting health care costs **Documentation** *If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.* • *Factors 1-2:* Reports showing performance. **Scoring** 100%: 2 factors 75%: No scoring option 50%: 1 factor 25% No scoring option 0%: 0 factors	• *General:* Factors in PCMH 2011, Element A are reorganized in PCMH 2014, Elements A and B. • PCMH 2011 Element A, factor 3 aligns with PCMH 2014 Element B, factor 2. • *New factor:* PCMH 2014 factor 1.
Element 6B: Measure Patient/Family Experience ***4 points*** The practice obtains feedback from patients/ families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: • Access • Communication • Coordination • Whole person care/self-management support 2. The practice uses the Patient-Centered Medical Home (PCMH) version of the CAHPS Clinician & Group Survey Tool 3. The practice obtains feedback on experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means	**Element 6C: Measure Patient/Family Experience** ***4 points*** At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: • Access • Communication • Coordination • Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool 3. The practice obtains feedback on experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means	• *General:* *PCMH 2014:* Adds 'at least annually.' • PCMH 2011 factors 1-4 aligns with PCMH 2014 factors 1-4.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Documentation • *Factors 1-4:* Reports showing results of patient feedback. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	**Documentation** *If this element is selected for the Multi-site Corporate Survey Tool, you must provide a report with data specified for each individual site in corporate tool.* • *Factors 1-4:* Reports showing results of patient feedback. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	
MUST-PASS **Element 6C: Implement Continuous Quality Improvement** ***4 points*** The practice uses an ongoing quality improvement process to: 1. Set goals and act to improve on at least three measures from Element A 2. Set goals and act to improve quality on at least one measure from Element B 3. Set goals and address at least one identified disparity in care/service for vulnerable populations 4. Involve patients/families in quality improvement teams or on the practice's advisory council **Documentation** • *Factors 1-3:* Report or completed PCMH Quality Measurement and Improvement Worksheet. • *Factor 4:* Process demonstrating how it involves patients/families in QI teams or advisory council.	**MUST-PASS** **Element 6D: Implement Continuous Quality Improvement** ***4 points*** The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least three clinical quality measures from Element A 2. Act to improve at least three clinical quality measures from Element A 3. Set goals and analyze at least one measure from Element B 4. Act to improve at least one measure from Element B 5. Set goals and analyze at least one patient experience measure from Element C 6. Act to improve at least one patient experience measure from Element C 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations **Documentation** • *Factors 1-7:* Report or completed PCMH Quality Measurement and Improvement Worksheet.	• PCMH 2011 factor 1 aligns with PCMH 2014 factors 1 and 2, with these differences: *PCMH 2011:* Evaluates whether the practice sets goals and acts to improve on at least three measures from Element A. *PCMH 2014:* Evaluates whether the practice sets goals, analyzes (factor 1) and acts to improve (factor 2) on at least three measures from Element A. • PCMH 2011 factor 2 has split into PCMH 2014 factors 5 and 6. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 7. • PCMH 2011 factor 4 aligns with PCMH 2014 Element 2D, factor 10. • *New factors:* PCMH 2014 factor 3. PCMH 2014 factor 4.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Scoring 100%: 3-4 factors 75%: No scoring option 50%: 2 factors 25% 1 factor 0%: 0 factors	**Scoring** 100%: 7 factors 75%: 6 factors 50%: 5 factors 25% 1-4 factors 0%: 0 factors	
Element 6D: Demonstrate Continuous Quality Improvement ***3 points*** The practice demonstrates ongoing monitoring the effectiveness of its improvement process by: 1. Tracking results over time 2. Assessing the effect of its actions 3. Achieving improved performance on one measure 4. Achieving improved performance on a second measure **Documentation** *Factors 1-4:* Reports showing measures over time, recognition results or completed Quality Measurement and Improvement Worksheet. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	**Element 6E: Demonstrate Continuous Quality Improvement** ***3 points*** The practice demonstrates-continuous quality improvement by: 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 2. Achieving improved performance on at least two clinical quality measures 3. Achieving improved performance on one utilization or care coordination measure 4. Achieving improved performance on at least one patient experience measure **Documentation** • *Factors 1-4:* Reports showing measures analysis of results over time, recognition results or completed Quality Measurement and Improvement Worksheet. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25% 1 factor 0%: 0 factors	• *General:* *PCMH 2011:* Evaluates whether the practice demonstrates ongoing monitoring of the effectiveness of its improvement process. *PCMH 2014:* Evaluates whether the practice demonstrates continuous quality improvement. • PCMH 2011 factor 1 has no PCMH 2014 equivalent. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 1, with these differences: *PCMH 2011:* Evaluates whether the practice assesses the effect of its actions. *PCMH 2014:* Evaluates whether the practice measures the effectiveness of the actions taken to improve the measures selected in Element D. • PCMH 2011 factors 3 and 4 align with PCMH 2014 factors 2-4, with these differences: *PCMH 2011:* Evaluates whether the practice achieves improved performance on two measures and does not specify the measures. *PCMH 2014:* Evaluates whether the practice achieve improved performance on at least two clinical quality measures (factor 2), one utilization or care coordination measure (factor 3) and at least one patient experience measure (factor 4).

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
Element 6E: Report Performance ***3 points*** The practice shares performance data from Element A and Element B: 1. Within the practice, results by individual clinician 2. Within the practice, results across the practice 3. Outside the practice to patients or publicly, results across the practice or by clinician **Documentation** • *Factors 1 and 2:* Reports (blinded) showing summary data by clinician and across the practice shared with the practice *and* how the results are shared. • *Factor 3:* Example of reporting to patients or the public. **Scoring** 100%: 3 factors 75%: 2 factors 50%: 1 factor 25% No scoring option 0%: 0 factors	**Element 6F: Report Performance** ***3 points*** The practice produces performance data reports using measures from Elements A, B and C and shares: 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice 3. Individual clinician or practice-level performance results publicly 4. Individual clinician or practice-level performance results with patients **Documentation** • *Factors 1, 2:* Reports (blinded) showing summary data by clinician and across the practice shared with the practice and description of how the results are shared. • *Factor 3, 4:* Example of reporting. **Scoring** 100%: 3-4 factors 75%: 2 factors 50%: 1 factor 25% No scoring option 0%: 0 factors	• *General:* *PCMH 2011:* Evaluates whether practices share performance data. *PCMH 2014:* Evaluates whether practices produce and share performance data reports. • PCMH 2011 factor 1 aligns with PCMH 2014 factor 1. • PCMH 2011 factor 2 aligns with PCMH 2014 factor 2. • PCMH 2011 factor 3 has been split into PCMH 2014 factors 3 and 4.
Element 6F: Report Data Externally ***2 points*** The practice electronically reports: 1. Ambulatory clinical quality measures to CMS+ 2. Ambulatory clinical quality measures to other external entities 3. Data to immunization registries or systems++ 4. Syndromic surveillance data to public health agencies++ **Documentation** • *Factors 1 and 2:* Reports (blinded) showing summary data by clinician and across the practice shared with the practice *and* how the results are shared.	**Element 6G**: **Use Certified EHR Technology** ***Not Scored*** The practice uses a certified EHR system 1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID++ 2. The practice to conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies+ 3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically+	• *General:* Factors in PCMH 2011 Elements F and G have been reorganized in PCMH 2014 Element G. • PCMH 2011 factors 1 and 2 have no PCMH 2014 equivalent. • PCMH 2011 factor 3 aligns with PCMH 2014 factor 7. • PCMH 2011 factor 4 aligns with PCMH 2014 factor 3. • *New factors:* PCMH 2014 factors 4-6. PCMH 2014 factors 8-10.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
• *Factors 3 and 4:* Reports demonstrating electronic data submittal to immunization registries and public health agencies or a screen shot demonstrating that capability was tested. **Scoring** 100%: 3-4 factors 75%: 2 factors 50%: 1 factors 25% No scoring option 0%: 0 factors	4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically+ 5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically + 6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use++ 7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically + 8. The practice has access to a health information exchange. 9. The practice has bidirectional exchange with a health information exchange 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+ + Meaningful Use Modified Stage 2 Alignment ++ CMS Meaningful Use Requirement This element is for data collection purposes only and will not be scored.	
Element G: Use Certified EHR Technology ***Not Scored*** This element is for data collection purposes only and *will not be scored*. ***Note:*** *Factor 1 requires comments*. 1. The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List (CHPL) Number(s) under the ONC (Office of the National Coordinator for Health Information Technology) HIT certification program+ 2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules) and implementing security updates as		• *General:* Factors in PCMH 2011, Elements F and G have been reorganized in PCMH 2014 Element G. • PCMH 2011 Element G, factors 1 and 2 align with PCMH 2014 Element G, factors 1 and 2.

Standard/Element/Factor		
PCMH 2011	**PCMH 2014**	**PCMH 2011-PCMH 2014 Alignment**
necessary and correcting identified security deficiencies+ **Documentation** • *Factor 1:* CHPL numbers entered in Survey Tool text box. • *Factor 2:* Entering "yes" in the Survey Tool is attestation to the appropriate security analysis and updates.		