Appendix 5

PCSP–PCMH 2014 Crosswalk

APPENDIX 5

PCSP–PCMH 2014 Crosswalk

The table compares NCQA's Patient-Centered Specialty Practice (PCSP) standards with NCQA's Patient-Centered Medical Home (PCMH) 2014 standards. The column on the right identifies items that are the same or similar and notes differences.

Meaningful Use Alignment

The NCQA PCSP Recognition program was developed to align with the NCQA PCMH 2014 Recognition program and with Meaningful Use Stage 2 criteria. Alignment has been updated to reflect the Meaningful Use Modified Stage 2 Final Rule released in October 2015.

Standard/Element/Factor		
PCSP +Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 +Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
PCSP 1: Track and Coordinate Referrals The practice coordinates patient care with primary care practices, referring clinicians and patients to ensure a timely exchange of information. ***22 points***		
MUST-PASS **Element 1A: Referral Process and Agreement** ***9 points*** The practice has a written process for implementing and managing referrals with PCPs and other referring clinicians including: 1. Formal and informal agreements with a subset of referring clinicians based on established criteria 2. Specified methods of communication with PCPs and the referring clinician (if not the PCP) 3. Specified method of communicating with the patient/family/caregiver about specialist's plan of care 4. Specified co-management or transition strategy for selected patients 5. Confirmation of receipt and acceptance of referral with date and time of the appointment	**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	• *General:* PCSP Elements 1A-C align with PCMH 2014 Element 5B. Factors do not align exactly because responsibilities between specialty practices and primary care practices differ. – *PCSP:* Evaluates the referral process and agreement with PCPs and other referring clinicians. – *PCMH:* Evaluates the referral, referral tracking and follow-up by the primary care practice. • PCSP factor 1 aligns with PCMH factor 2. • PCSP factor 2 has no PCMH equivalent. • PCSP factor 3 has no PCMH equivalent. • PCSP factor 4 and PCSP Element 5B, factor 5 align with PCMH factor 9, with these differences: – *PCSP:* Specifies co-management or transition strategy for selected patients. – *PCMH:* Documents co-management arrangements in the medical record.

Standard/Element/Factor		
PCSP +Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 +Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
6. Specified information needed from referring clinician about patients 7. Specified information and timing of the referral response to PCPs and referring clinicians (if not the PCP) 8. Type and method of communication with the patient and family/caregiver about results and treatment **Documentation** • *Factors 1-8:* Documented process. • *Factors 1-8:* Three examples that show implementation. **Scoring** 100%: 6-8 factors 75%: 4-5 factors 50%: 2-3 factors 25%: No scoring option 0%: 0-1 factors	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+ 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 **Documentation** • *Factors 1,5,6,8,10:* Documented process and at least one example. • *Factors 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:* Report based on at least three months of data with numerator, denominator and percent. • *Factor 9:* The practice provides at least three 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 0%: 0-1 factors	• PCSP factor 5 has no PCMH equivalent. • PCSP factor 6 has no PCMH equivalent. • PCSP factor 7; Element 1B, factors 1-6; and Element 5B, factors 2 and 3 have been reorganized in PCMH Element 5B, factors 5, 6 and 8. • PCSP factor 8 has no PCMH equivalent.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Element 1B: Referral Content ***5 points*** The practice has a written process and monitors against it to ensure receipt of information needed in referrals from referring clinicians: 1. Clinical question(s) to be answered by the referral 2. Type of referral 3. Urgency of referral 4. Patient demographics 5. Clinical information 6. Current primary practice care plan, treatment, test results and procedures 7. Communication with patient/family **Documentation** • *Factors 1-7:* Documented process. • *Factors 1-7:* Three examples of implementation. • *Factors 1-7:* Report demonstrating information provided by referring clinicians based on at least 30 days of data. **Scoring** 100%: 5-7 factors 75%: 3-4 factors 50%: 1-2 factors 25%: No scoring option 0%: 0 factors		

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
MUST-PASS **Element 1C: Referral Response** ***8 points*** The practice has a written process and monitors against it to ensure a timely response to PCPs, referring clinicians and patients that includes: 1. Answer(s) to clinical question(s) in referral 2. Diagnosis 3. Procedures and test results 4. Recommended specialist's plan of care, care management, patient education, secondary referrals 5. Follow-up needed with specialist including further coordination 6. Tracking system for monitoring timeliness of referral response 7. Tracking system for confirming receipt of the referral and sending date and time of the appointment to the referring clinician 8. Providing an electronic summary of care record to another provider for more than 50 percent of referrals+ **Documentation** • *Factors 1-8:* Documented process. • *Factors 1-5:* Report showing completeness of response based on at least 30 days of data. • *Factor 6-7:* Report showing timeliness of referral response based on at least 30 days of data. • *Factor 8:* MU Report. **Scoring** 100%: 6-8 factors 75%: 4-5 factors 50%: 3 factors 25%: 1-2 factors 0%: 0 factors		• *General:* PCSP Elements 1A-1C align with PCMH 2014 Element 5B. Factors do not align exactly because responsibilities between specialty practices and primary care practices differ. – *PCSP:* Evaluates the referral response to PCPs, referring clinicians and patients. – *PCMH:* Evaluates the referral, referral tracking and follow-up by the primary care practice.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
PCSP 2: Provide Access and Communication The practice provides timely access to culturally and linguistically appropriate team-based clinical advice and care that meets the needs of patients/families/ caregivers. ***18 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***	
Element 2A: Access ***5 points*** The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards to: 1. Provide patient appointments based on patient need 2. Provide same day appointments 3. Provide non-visit consultations with referring clinicians 4. Provide timely clinical advice to patients who contact the office when the office is open 5. Provide timely clinical advice to patients who contact the office when the office is closed 6. Document clinical advice to established patients in the patient medical record 7. Provide equal access to accepted patients regardless of source of payment. 8. Provide uninsured patients with information about obtaining coverage **Documentation** • *Factors 1-8:* Documented or written process for staff to follow (including clinicians). • *Factors 1-6:* Three examples documenting implementation. • *Factor 7:* Materials provided to uninsured, Medicare and Medicaid patients in practice population demonstrating their nondiscriminatory policy and an example of the public and private payers and uninsured in the practice. • *Factor 8:* Process and materials or link to potential insurance sources (e.g., Medicaid, CHIP, Medicare).	**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:* Documented process and • *Factor 1:* Report with at least 5 days of data showing same-day access. • *Factor 2:* Report with at least 5 days of data showing after hours availability **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 now shows from a recent 30-calendar-day period.	• PCSP factor 1 has no PCMH equivalent. • PCSP factor 2 aligns with PCMH factor 1, with this difference: – *PCMH:* Specifies appointments are for routine and urgent care. • PCSP factor 3 has no PCMH equivalent. • PCSP factor 7 aligns with PCMH Element 2B, factor 6. • PCSP factor 8 aligns with PCMH Element 2B, factor 7. • *New factors:* – PCMH factors 2-6.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Scoring 100%: 6-8 factors 75%: 4-5 factors 50%: 2-3 factors 25%: 1 factor 0% 0 factors	• *Factor 6:* Report showing the practice 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)	
	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:* Documented process for arranging after-hours access, making medical records available 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.	• PCSP factors 4 and 5 have been reorganized into PCMH factors 2 and 3, with these differences: – *PCSP:* Does not specify mode of communication. – *PCMH:* Mode of communication specifies telephone and secure electronic message. • PCSP factor 6 aligns with PCMH factor 4. • PCMH factor 1 has no PCSP equivalent.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	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)	
Element 2B: Electronic Access ***2 points*** The practice provides the following information and services to patients/families/caregivers 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, download or transmit to a third party their health information+ 3. Clinical summaries are provided to patients/ families/caregivers within 1 business day for more than 50% of office visits 4. A secure message was sent by more than 5 percent of patients+ 5. Two-way communication between patients/families/ caregivers and the practice 6. Request for appointments, prescription refills and test results **Documentation** • *Factors 1-4:* Report based on numerator, denominator and a percentage for a recent 12 months (or 3 months) of data in the electronic system. • *Factors 5, 6:* Screen shots showing the capability of the system.	**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 **Documentation** • *Factors 1-4:* Report based on numerator and denominator for at least 3 months of data in the electronic system. • *Factors 5, 6:* Screen shots showing the capability of the practice's system.	• PCSP factors 1-4 align with PCMH factors 1-4 • PCSP factor 5 aligns with PCMH factor 5, with these differences: – *PCSP:* Includes communication with families and caregivers. • PCSP factor 6 aligns with PCMH factor 6.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Scoring 100%: 5-6 factors 75%: 4 factors 50%: 3 factors 25%: 1-2 factors 0%: 0 factors	**Scoring** 100%: 5-6 factors 75%: 3-4 factors 50%: 2 factors 25%: 1 factor 0%: 0 factors	
	PCMH 2: Team-Based Care The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches. ***12 points***	
NA **Continuity with a provider is not expected for specialty practices.**	**Element 2A: Continuity** ***3 points*** The practice provides continuity of care for patients/familiesby: 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 **Documentation** • *Factor 1:* 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:* 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 documented process and materials for outreach; for internal medicine practices a documented process.	**NA**

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	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 2C: Specialty Practice Responsibilities *4 points* The practice has a process and materials that it provides to patients/families/caregivers about: 1. Role of the specialist 2. Methods, content and frequency of communication with the patient (e.g. test results, care management, medications, after-hours contact) 3. Coordination of care between the primary care clinician, the referring clinician, the specialist and the patient/family/caregiver **Documentation** • *Factors 1-3:* Documented process. • *Factors 1-3:* Materials such as brochures, Web materials or letter to patients. **Scoring** 100%: 3 factors 75%: No scoring option 50%: 2 factors 25%: 1 factor 0%: 0 factors	**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 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	• *General:* PCMH Element C and PCSP Element C both provide patients with *information* about the role of the practice and the expectations of both the patient and the practice. Factors do not align exactly because responsibilities between specialty practices and primary care practices differ. • PCMH Element 2B, factor 6 aligns with PCSP Element 2A, factor 7. • PCMH Element 2B, factor 7 aligns with PCSP Element 2A, factor 8. • *New factors:* – PCMH factors 5 and 8.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	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 2D: Cultural 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/caregivers. 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 and 2:* A report showing ethnic and language composition of the practice's patients. • *Factor 3:* Documentation that interpretive services are available or there is a policy for using bilingual staff. • *Factor 4:* Provide or show access to materials in languages needed by ≥5 percent of the practice's population, including online materials to meet this requirement.	**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 and language composition of its patient population. • *Factor 3:* 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	• PCSP factor 1 aligns with PCMH factor 1, with these differences: – *PCSP:* Assesses the racial and ethnic diversity of its population. – *PCMH:* Assesses an expanded definition of diversity (which includes race and ethnicity) of its population. • PCSP factors 2-4 align with PCMH factors 2-4.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Scoring 100%: 4 factors 75%: 3 factors 50%: 2 factors 25%: 1 factor 0%: 0 factors		
MUST-PASS **Element 2E: The Practice Team** ***5 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 focused on patients 3. Using standing orders for services 4. Training and assigning care teams to coordinate care 5. Training and designating care team members in communication skills 6. Involving care team staff in the practice's performance evaluation and quality improvement activities 7. Holding regular practice team meetings **Documentation** • *Factor 1:* Staff job descriptions. • *Factor 2:* Description of structured team communication on patients and examples. • *Factor 3:* Example of standing orders. • *Factors 4, 5:* Description of training process. • *Factor 6:* Description of how staff are engaged in practice evaluation and improvement. • *Factor 7:* Description of practice team meetings and example.	**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 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	• PCSP factor 1 aligns with PCMH factor 1. • PCSP factor 2 aligns with PCMH factor 3, with this difference: – *PCMH:* Specifies that the team meeting is about patient care and the structured communication process focuses on individual patient care. • PCSP factor 3 aligns with PCMH factor 4. • PCSP factor 4 aligns with PCMH factor 5, with this difference: – *PCMH:* Specifies care is coordinated for individual patients. • PCSP factor 5 has no PCMH equivalent. • PCSP factor 6 aligns with PCMH factor 9. • PCSP factor 7 aligns with PCMH factor 8, with this difference: – *PCMH:* Specifies the regular practice team meeting addresses practice functioning. • PCMH factors 6, 7 and 10 have no PCSP equivalent. • *New factor:* – PCMH factor 2.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Scoring 100%: 5-7 factors 75%: 4 factors 50%: 3 factors 25%: 1-2 factors 0%: 0 factors	**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)	

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
PCSP 3: Identify and Coordinate Patient Populations The practice systematically records patient information and uses it to coordinate care for patient populations. ***10 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 3A: Patient Information ***3 points*** The practice uses an electronic system that records the following as structured (searchable) data for more than 80 percent of the patients. 1. Date of birth 2. Sex 3. Race 4. Ethnicity 5. Preferred language 6. Telephone numbers 7. E-mail address 8. Primary caregiver 9. Occupation 10. Presence of advance directives 11. Health insurance information 12. Name and contact information of primary care clinician 13. Name and contact information of other specialists 14. Practice-patient relationship status (e.g. co-management) **Documentation** • *Factors 1-12:* Report with numerator and denominator with 12 months (or 3 months) of data. • *Factors 13, 14:* Data do not need to be searchable or structured. Documentation should be a written process identifying how and where this information is captured on patients.	**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. Documentation should be a written process and screen shots identifying how and where this information is captured on patients and three examples.	• *General*: PCSP Element A stem aligns with PCMH Element A stem • PCSP factors 1-7 align with PCMH factors 1-7. • PCSP factor 8 aligns with PCMH factor 11. • PCSP factor 9 aligns with PCMH factor 8, with this difference: – *PCMH:* Not applicable for pediatric practices. • PCSP factor 10 aligns with PCMH factor 12, with this difference: – *PCMH:* Not applicable for pediatric practices. • PCSP factor 11 aligns with PCMH factor 13. • PCSP factor 12 and 13 align with PCMH 14. • PCSP factor 14 has no PCMH equivalent. • PCMH factor 9 and 10 have no PCSP equivalent.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Scoring 100%: 10-14 factors 75%: 8-9 factors 50%: 5-7factors 25%: 3-4 factors 0%: 0-2 factors	**Scoring** 100%: 10-14 factors 75%: 8-9 factors 50%: 5-7 factors 25%: 3-4 factors 0%: 0-2 factors	
Element 3B: 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 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 (NA for pediatric practices) 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 health history recorded as structured data Enter 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	**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	• PCSP factors 1 and 2 align with PCMH factors 1 and 2. • PCSP factors 3-5 align with PCMH factors 3-5 • PCSP factor 6 aligns with PCMH factor 6, with this difference: – *PCMH:* Not applicable for pediatric practices. PCSP factor 7 aligns with PCMH factor 7. • PCSP factor 8 aligns with PCMH factor 8 • PCSP factor 9 aligns with PCMH factor 9 • PCSP factor 10 aligns with PCMH factor 10 • PCSP factor 11 aligns with PCMH factor 11

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Documentation • *Factors 1-5, 8-11:* Reports with a numerator and denominator. • *Factors 6, 7:* Screen shots demonstrating capability. **Scoring** 100%: 9-11 factors 75%: 7-8 factors 50%: 5-6 factors 25%: 3-4 factors 0%: 0-2 factors	**Documentation** • *Factors 1-5, 8-11:* Reports with a numerator and denominator. • *Factors 6, 7:* Screen shots demonstrating capability. **Scoring** 100%: 9-11 factors 75%: 7-8 factors 50%: 5-6 factors 25%: 3-4 factors 0%: 0-2 factors	
NA	**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) 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	**NA**

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	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 of the information in the Record Review Workbook. If using the Record Review Workbook examples are required demonstrating how each factor is documented. • *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	
Element 3C: Coordinate Patient Populations ***3 points*** The practice uses patient information, clinical data and evidence-based guidelines to: 1. Generate lists of patients and proactively remind patients/families/caregivers of services needed or coordinate with primary care for one condition-related service 2. Generate lists of patients and proactively remind patients/families/caregivers of services needed or coordinate with primary care for a second condition-related service 3. Generate lists of patients and proactively remind patients/families/caregivers of services needed or coordinate with primary care for a third condition-related service 4. Generate lists of patients and proactively remind more than 10 percent of patients/families/caregivers (or	**MUST-PASS** **Element 3D: Use Data for Population Management** ***5 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 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.	• *General:* PCMH Element D and PCSP Element C both evaluate whether the practice uses patient information, clinical data and evidence-based guidelines to manage patient populations, with this difference: – PCSP factors 1–3 state practice coordinate services needed with primary care. • PCSP factor 4 aligns with PCMH 6G factor 10 with slight differences. • PCSP factor 5 aligns with PCMH 3E with slight differences.

Standard/Element/Factor		
PCSP **+ Meaningful Use Modified Stage 2 Alignment**	**PCMH 2014** **+ Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
coordinate with primary care for these patients) for needed preventive/follow-up care 5. Implement at least 5 clinical decision support intervention(s)+ **Documentation** • *Factors 1-4: For each factor, the practice provides:* Reports or lists of patients needing services **AND** materials showing how patients are notified of needed service. • *Factor 5:* Examples of clinical decision support interventions. **Scoring** 100%: 4-5 factors 75%: 3 factors 50%: 1-2 factors 25%: No scoring option 0%: 0 factors	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%: 1-2 factors 25%: No scoring option 0%: 0 factors	
Standard/Element/Factor		
PCSP 4: Plan and Manage Care The practice collaborates with the referring clinician and the patient/family/caregiver to plan and manage care and provide self-care support. ***18 points***		
NA	**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+ 4. A condition related to unhealthy behaviors+ 5. Well child or adult care+	• PCSP 3C factor 5 aligns with PCMH 3E with slight differences.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	6. Overuse/appropriateness issues+ **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 4: Care Management and Support The practice systematically identifies individual patients and plans, manages and coordinates care, based on need. ***20 points***	
NA	**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 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.	**NA**

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	• *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 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)	
CRITICAL FACTORS = FACTORS 3 and 4 **Element 4A: Care Planning and Support Self-Care** ***11 points*** The practice collaborates with the referring clinician and the patient/family/caregiver to plan and manage care and provide self-care support. 1. Conduct pre-visit preparations 2. Assess patient risk status to identify patients needing additional support and services 3. Collaborate with the patient/family/caregiver to develop a specialist's plan of care that includes patient's goals, potential barriers and self-care ability 4. Share specialist's plan of care including recommendations for self-care support with the PCP and referring clinician 5. Give the patient/family/caregiver a written specialist's plan of care including self-care recommendations. 6. Provide educational resources or refer patients/families/caregivers to assist in self-management 7. Assess and address barriers when patient has not met treatment goals 8. Use an EHR to identify patient-specific education resources and provide to more than 10 percent of patients+	**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 submission ***OR*** Record Review Workbook. If using the Record Review Workbook examples are required demonstrating how each factor is documented.	• General*:* PCSP Element A and PCMH Element B both evaluate whether the practice develops care plans, but factors do not align exactly because responsibilities between specialty practices and primary care practices differ. – *PCSP:* Does not specify that care team perform care management activities for at least 75% of patients identified in the previous elements. – *PCMH:* Specifies that care team perform care management activities for at least 75% of patients identified in the previous elements and that data be abstracted from the patient record for each factor and stated conditions.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Documentation • *Factors 1-7:* Written process and examples. • *Factor 8:* Report with numerator and denominator. **Scoring** 100%: 6-8 factors, including factors 3, 4 75%: 4-5 factors, including factors 3, 4 50%: 2-3 factors, including factors 3, 4 25%: 1 factor 0%: 0 factor	**Scoring** 75% of patients for each factor 100%: 5 factors 75%: 4 factors 50%: 3 factors 25%: 1-2 factors 0%: 0 factors	
MUST-PASS **Element 4B: Medication Management** ***5 points*** The practice has a process and demonstrates that it systematically manages medications prescribed by the practice in the following ways: 1. Reviews and reconciles medications for more than 50 percent of patients received from another care setting or at a relevant visit+ 2. Provides information about new prescriptions from specialty practice to patients/families/caregivers. 3. Coordinates medication management and reconciliation with the PCP, referring clinician and patient/family/caregiver 4. Assesses patient/family/caregiver understanding of medications from specialty practice 5. Assesses patient response to medications from specialty practice and barriers to adherence 6. Documents over-the-counter medications, herbal therapies and supplements **Documentation** • *Factors 1-6:* Process and examples.	**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	• *General:* – *PCSP:* Medication management is only expected for medications prescribed by the specialty practice. • PCSP factor 1 aligns with PCMH factor 1. • PCSP factor 2 aligns with PCMH factor 3, with these differences: – *PCSP:* Provides information, but there is no minimum threshold. – *PCMH:* Provide information to more than 80 percent of patients/families/caregivers. • PCSP factor 3 has no PCMH equivalent. • PCSP factor 4 aligns with PCMH factor 4, with these differences: – *PCSP:* Assesses understanding of medications, but there is no minimum threshold. – *PCMH:* Assesses understanding of medications for more than 50 percent of patients/families/caregivers with the date of the assessment.

Standard/Element/Factor		
PCSP **+ Meaningful Use Modified Stage 2 Alignment**	**PCMH 2014** **+ Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Scoring 100%: 5-6 factors 75%: 4 factors 50%: 3 factors 25%: 2 factors 0%: 0-1 factors	**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)	• PCSP factor 5 aligns with PCMH factor 5, with these differences: – *PCSP:* Assesses patient response to medications, but there is no minimum threshold. – *PCMH:* Assesses patient response to medications for more than 50 percent of patients/families/caregivers with the date of the assessment. • PCSP factor 6 aligns with PCMH factor 6, with these differences: – *PCSP:* Documents over-the-counter medications, herbal therapies and supplements, but there is no minimum threshold. – *PCMH:* Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients/families/ caregivers with dates of updates.
Element 4C: Use of Electronic Prescribing ***2 points*** The practice uses an electronic prescription system with the following. 1. Writes at least 75 percent of eligible prescriptions electronically. 2. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies+ 3. Enters electronic medication orders into the medical record for more than 60 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.	**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	• PCSP factor 1 has no PCMH equivalent. • PCSP factor 2 aligns with PCMH factor 1 • PCSP factor 3 aligns with PCMH factor 2 • PCSP factor 4 aligns with PCMH factor 3. • PCSP factor 5 aligns with PCMH factor 4.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Documentation • *Factors 1-3:* Report with a numerator, denominator and a percentage. • *Factors 4, 5:* Screen shot demonstrating functionality. ***Note:*** *This element is NA for practices that do not prescribe medications. Points assigned to this element are redistributed to the other elements in Standard 4.* **Scoring** 100%: 3-5 factors 75%: 2 factors 50%: 1 factor 25%: No scoring option 0%: 0 factors	**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. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25%: 1 factor 0%: 0 factors	
PCMH 4, Element A: Support Self-Care Process has merged with PCSP Standard 4, Element A: Care Planning and Self-Care Support.	**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.	**NA**

Standard/Element/Factor		
PCSP **+ Meaningful Use Modified Stage 2 Alignment**	**PCMH 2014** **+ Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
	Documentation • *Factor 1:* Report showing percentage of patients provided educational resources. • *Factors 2-5:* For each factor, at least three examples of 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	
PCSP 5: Track and Coordinate Care The practice systematically tracks tests and referrals and coordinates care with the referring clinician and facilities. ***16 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 FACTOR = FACTOR 2 **Element 5A: Test Tracking and Follow-Up** ***5 points*** The practice has a documented process for and demonstrates that it: 1. Requests and tracks receipt of test results from PCP and referring clinician 2. Provides PCP and referring clinician with results of relevant tests ordered by the specialist 3. Tracks lab tests until results are available, flagging and following up on overdue results 4. Tracks imaging tests until results are available, flagging and following up on overdue results	**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	• PCSP factors 1 and 2 have no PCMH equivalent. • PCSP factor 3 aligns with PCMH factor 1. • PCSP factor 4 aligns with PCMH factor 2. • PCSP factor 5 aligns with PCMH factor 3. • PCSP factor 6 aligns with PCMH factor 4. • PCSP factor 7 aligns with PCMH factor 5. • PCSP factor 8 aligns with PCMH factor 7. • PCSP factor 9 aligns with PCMH factor 8. • PCSP factor 10 aligns with PCMH factor 9. • PCSP factor 11 aligns with PCMH factor 10. • PCMH factor 6 has no PCSP equivalent.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
5. Flags abnormal lab results, bringing them to the attention of the clinician 6. Flags abnormal imaging results, bringing them to the attention of the clinician 7. Patients/families/caregivers are notified about normal and abnormal lab and imaging test results 8. More than 30 percent of laboratory orders are electronically recorded in the patient record+ 9. More than 30 percent of radiology orders are electronically recorded in the patient record+ 10. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record 11. More than 10 percent of scans and tests that result in an image are accessible electronically **Documentation** • *Factors 1-7:* Written process. • *Factors 1-7:* Report with 5 days of data or three examples of the process that is met for each factor. • *Factors 8-11:* Report with a numerator and denominator. **Scoring** 100%: 5-7 factors, including factor 2 75%: 4 factors, including factor 2 50%: 3 factors, including factor 2 25%: 1-2 factors, including factor 2 0%: 0 factors or does not meet factor 2	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 **Documentation** • *Factors 1-6:* Documented process **AND** evidence showing how the process is met for each factor such as a report or log or examples (to 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	•

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
CRITICAL FACTOR = FACTOR 2 **Element 5B: Referral Tracking and Follow-Up** ***6 points*** The practice coordinates referrals to other (secondary) specialists by: 1. Consulting with PCP and referring clinician and patient/family/caregiver regarding secondary referrals 2. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information 3. Tracking the status of the referral, including required timing for receiving a specialist's report 4. Following up to obtain specialist's report 5. Establishing and documenting agreements with specialists in the medical record if co-management is needed 6. Asking patients/families about self-referrals and requesting reports from clinicians 7. Assuring the PCP and original referring clinician are notified of the secondary referral results. 8. Providing an electronic summary of care record to another provider for more than 50 percent of referrals+ 9. Electronically transmitting a summary of care record to another care provider for more than 10 percent of care referrals+ 10. Conducts one or more successful electronic exchanges with a recipient who has technology developed by a different EHR developer or successfully tests with the CMS designated test EHR+ **Documentation** • *Factors 1-4, 6 &:* Written process. • *Factors 1-4, 6 & 7:* Report or logs showing data collection in a tracking system. • *Factor 5:* NCQA reviews at least three examples. • *Factors 8, 9:* Report with numerator and denominator.	**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+ 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 **Documentation** • *Factors 1,5,6,8,10:* Documented process and at least one example. • *Factor 2,3:* For each factor, the practice provides at least one example.	• *General:* Factors do not align exactly because responsibilities between specialty practices and primary care practices differ. • PCSP factor 1 has no PCMH equivalent. • PCSP factors 2 and 3; Element 1A, factor 7; and Element 1B, factors 1-6 have been reorganized in PCMH factors 5, 6 and 8, with these differences: – *PCSP:* Gives the consultant or specialist pertinent clinical information. – *PCMH:* Gives consultant or specialist pertinent demographic and clinical data, including test results and the current care plan and flags and follows up on overdue reports. • PCSP factors 4 has no PCMH equivalent. • • PCSP factor 5 aligns with PCMH factor 9, with these differences: – *PCSP:* Evaluates that a practice establishes and documents agreements with specialists in the medical record, if co-management is needed. – *PCMH:* Evaluates that a practice documents co-management arrangements in the medical record. • PCSP factor 6 aligns with PCMH factor 10. • PCSP factor 7 has no PCMH equivalent. • PCSP factors 8 and 10 have been reorganized in PCMH factor 7. • PCSP factor 9 have no PCMH equivalent. • *New factors:* – PCMH factors 1-4.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
11. *Factor 10:* Screen shot showing capability. **Scoring** 100%: 8-10 factors, including factor 2 75%: 6-7 factors, including factor 2 50%: 4-5 factors, including factor 2 25%: 1-3 factors, including factor 2 0%: 0 factors	• *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 of transitions, or 3 months if 12 months not available; provide a written explanation for NA. • *Factor 9:* The practice provides at least three 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)	
Element 5C: Coordinate Care Transitions ***5 points*** For conditions managed by the specialist, 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 3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities 4. Demonstrates its process for transitioning patients back to the primary care practice 5. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care+ 6. Electronically transmits a summary of care record to another care setting for more than 10 percent of care transitions+	**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 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+	• *General:* – *PCSP:* Evaluates the practice on conditions managed by the specialist – *PCMH:* Evaluates the practice. • PCSP factor 1 aligns with PCMH factor 1 with these differences: – *PCSP:* Evaluates the process for identifying patients with a hospital admission and emergency department visit. – *PCMH:* Evaluates the process for proactively identifying patients with unplanned hospital admissions and emergency department visits. • PCSP factors 2 and 3 align with PCMH factors 2 and 3. • PCSP factor 4 has no PCMH equivalent. • PCSP factor 5 partially aligns with PCMH factor 7, with this difference: – *PCSP:* Does not evaluate the ability for electronic exchange of key clinical information with facilities. • PCSP factor 6 has no PCMH equivalent. • PCMH factors 4 and 5 have no PCSP equivalent.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Documentation • *Factors 1-4:* Written process and examples. • *Factors 5, 6:* Require a report with a numerator and denominator. **Scoring** 100%: 4-6 factors 75%: 3 factors 50%: 2 factors 25%: 1 factor 0%: 0 factors	**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	• *New factor:* – PCMH factor 6.
PCSP 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. ***16 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 ***5 points*** The practice measures or receives data on: 1. At least three clinical measures related to the practice specialty 2. Coordination of care results 3. At least two utilization measures affecting health care costs 4. Performance data stratified for vulnerable populations (to assess disparities in care) 5. Timely access to appointments based on established criteria	**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).	• *General:* Factors do not align exactly because responsibilities between specialty practices and primary care practices differ. • *General:* PCSP Element A stem is aligned with PCMH Element A stem, with these differences: – *PCSP:* Evaluates the practice measures or receives data. – *PCMH:* Evaluates the practice measures or receives data at least annually. • PCSP factor 1 aligns with PCMH factors 1-3, with these differences:

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Documentation *Factors 1-5:* Reports showing performance. **Scoring** 100%: 4-5 factors 75%: 3 factors 50%: 1-2 factors 25%: No scoring option 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 performance. **Scoring** 100%: 4 factors 75%: 3 factors 50%: 2 factors 25%: 1 factor 0%: 0 factors	– *PCSP:* Evaluates the practice measures or receives data on at least three clinical measures related to the practice specialty. – *PCMH:* Evaluates the practice measures or receives data on at least immunization measures, two other preventive care measures and at least three chronic or acute care clinical measures. • PCSP factor 2 has no PCMH equivalent. • PCSP factor 4 aligns with PCMH factor 4. • PCSP factor 5 has no PCMH equiivalent
	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 do not align exactly because responsibilities between specialty practices and primary care practices differ. • *General:* – *PCSP:* Evaluates the practice measures or receives data. – *PCMH:* Evaluates the practice measures or receives quantitative data at least annually. • PCSP factor 3 aligns with PCMH factor 2 • *New factor:* – PCMH factor 1.

Standard/Element/Factor		
PCSP **+ Meaningful Use Modified Stage 2 Alignment**	**PCMH 2014** **+ Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Element 6B: Measure Patient/Family Experience ***6 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 • Self-management support 2. The practice uses the CAHPS Clinician & Group (CG) Survey Tool 3. The practice obtains feedback on experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means **Documentation** • *Factors 1-4:* Reports showing performance. **Scoring** 100%: 4-5 factors 75%: 3 factors 50%: 1-2 factors 25%: No scoring option 0%: 0 factors	**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 **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	• *General:* – *PCSP:* Evaluates the practice obtains feedback from patients/families. measures or receives data. – *PCMH:* Evaluates the practice obtains feedback from patients/families at least annually. • PCSP factor 1 aligns with PCMH factor 1, with this difference: – *PCSP:* Omits "whole person care" from the "self-management support" category option. • PCSP factor 2 aligns with PCMH factor 2. • PCMH factors 3 and 4 align with PCSP factors 3 and 4.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
MUST-PASS **Element 6C: Implement & Demonstrate Continuous Quality Improvement** ***4 points*** The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by: 1. Setting goals and acting to improve on at least three clinical quality or utilization measures 2. Setting goals and acting to improve quality on at least one patient experience measure 3. Setting goals and acting to improve timeliness of patient access 4. Setting goals and acting to improve coordination with primary care. 5. Tracking results over time 6. Assessing the effect of its actions 7. Achieving improved performance on one measure 8. Achieving improved performance on a second measure 9. Setting goals and addressing at least one identified disparity in care/service for vulnerable populations **Documentation** • *Factors 1-8:* Reports or completed Quality Measurement and Improvement Worksheet. • *Factor 9:* Written process and examples of how disparities are addressed. **Scoring** 100%: 6-9 factors 75%: 4-5 factors 50%: 3-4 factors 25%: 2 factors 0%: 0-1 factors	**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. **Scoring** 100%: 7 factors 75%: 6 factors 50%: 5 factors 25%: 1-4 factors 0%: 0 factors	• *General* – *PCSP:* Evaluates that practices demonstrate ongoing monitoring of the effectiveness of their improvement process. – *PCMH:* Evaluates that practices use an ongoing quality improvement process. • PCSP factor 1 aligns with PCMH factors 1-4, with these differences: – *PCSP:* Specifies measures must be 3 clinical quality or utilization measures and evaluates whether the practice sets goals and acts to improve on at least three clinical quality or utilization measures. – *PCMH:* Allows any 3 measures from Element A, which includes immunization measures, other preventive care measures and chronic or acute care clinical measures and at least 1 measure from Element B and evaluates whether the practice sets goals, analyzes (factors 1 and 3) and acts to improve (factors 2 and 4) on at least three measures from Element A and one measure from Element B. • PCSP factor 2 aligns with PCMH factors 5 and 6, with these differences: – *PCSP:* Evaluates whether the practice sets goals and acts to improve at least one patient experience measure. – *PCMH:* Evaluates whether the practice sets goals, analyzes (factor 5) and acts to improve (factor 6) on at least one patient experience measure from Element C. • PCSP factors 3-5 have no PCMH equivalent.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
		• PCSP factor 9 aligns with PCMH factor 7, with these differences: – *PCMH:* Evaluates disparity in care/service for vulnerable populations. Does not include the term "identified." • *PCMH:* Evaluates disparity in care/service for vulnerable populations identified.
	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	• PCSP factor 6 aligns with PCMH factor 1, with these differences: – *PCSP:* Evaluates whether the practice assesses the effect of its actions. – *PCMH:* Evaluates whether the practice measures the effectiveness of the actions taken to improve the measures selected in Element D. • PCSP factors 7 and 8 partially aligns with PCMH factors 2-4, with these differences: – *PCSP:* Evaluates whether the practice achieves improved performance on two measures. – *PCMH:* Evaluates whether the practice achieves improved performance on at least two clinical quality measures (factor 2), one utilization or care coordination level (factor 3) and at least one patient experience measures (factor 4).

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
Element 6D: Report Performance ***2 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** • Reports. • Example of report 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	• PCSP factor 1 aligns with PCMH factor 1. • PCSP factor 2 aligns with PCMH factor 2. • PCSP factor 3 has split into PCMH factor 3 and factor 4.
Element 6E: Use Certified EHR Technology ***Not Scored*** This element is for data collection purposes only and *will not be scored.* ***Note:*** *Factor 1 requires entering the CHPL number(s) in NCQA's Web-based survey tool.* 1. The practice uses an EHR system (or modules) that has been certified and issued a CMS Certification ID++ 2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules) and implementing security updates as necessary and correcting identified security deficiencies+	**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+	• PCSP factors 1-7 aligns with PCMH factors 1-7. • PCMH factor 10 aligns with PCSP 3C factor 4 with slight differences. • *New factors:* – PCMH factors 8 and 9.

Standard/Element/Factor		
PCSP + Meaningful Use Modified Stage 2 Alignment	**PCMH 2014 + Meaningful Use Modified Stage 2 Alignment**	**PCSP-PCMH 2014 Alignment**
3. The practice demonstrates capability to submit electronic syndromic surveillance data to public health agencies electronically+ 4. The practice demonstrates capability to identify and report cancer cases to a public health central cancer registry electronically+ 5. The practice demonstrates capability to identify and report specific cases to a specialized registry electronically (other than a cancer registry)+ 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 electronic data to immunization registries or immunization information systems.+ ***This element is for data collection purposes only and will not be scored.***	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 ***This element is for data collection purposes only and will not be scored.***	