

# Transition Document for NCQA 2014 Standards Compared to NCQA 2017 Concepts

Updated 5/1/17

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

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<p><b>1:B:4</b> Documenting clinical advice in patient records. It reconciles this information with the medical record the next business day.</p>	<p><b>AC-05 (Core):</b> Practice documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record.</p>
<p><b>PCMH 1: Patient-Centered Access- Electronic Access, Element C</b></p>	<p><b>Matching NCQA 2017 Criteria</b></p>
<p><b>1:C:1</b> 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.</p>	<p><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>1:C:2</b> 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.</p>	<p><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>1:C:3</b> Clinical summaries are provided within 1 business day for more than 50 percent of office visits.</p>	<p><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>1:C:4</b> A secure message was sent by more than 5 percent of patients.</p>	<p><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>1:C:5</b> Practice has a secure, interactive electronic system, such as a website, patient portal, or a secure e-mail system that allows two-way communication between patients/families/caregivers, as applicable for a patient, and the practice.</p>	<p><b>AC-08 (1 Credit):</b> has a secure electronic system for patient for two-way communication to provide timely clinical advice.</p>
<p><b>1:C:6</b> Patients can use the secure electronic system (e.g., website or patient portal) to request appointments, medication refills, referrals to other providers and get test results.</p>	<p><b>AC-07 (1 Credit):</b> Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results.</p>

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

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

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

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

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

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NCQA 2014, Standard 3	2017 Criteria
<p><b>3:B:10</b> More than 20 percent of patients have family history recorded as structured data.</p>	<p><b>KM-02 (Core):</b> Comprehensive health assessment includes A. Medical history of patient and family.</p>
<p><b>3:B:11</b> 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.</p>	<p><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>PCMH 3: Population Health Management – Comprehensive Health Assessment, Element C</b></p>	<p><b>Matching NCQA 2017 Criteria</b></p>
<p><b>3:C:1-10</b> To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes (factors 1-10).</p>	<p><b>KM-02 (Core):</b> Comprehensive health assessment includes A-I items (all items required).</p>
<p><b>3:C:6</b> Behaviors affecting health  <b>3:C:7</b> Mental health/substance use history of patient and family.  <b>These factors are related to 2017 Standards, KM-04, but are not exactly the same because the 2014 Standards don't require screening specifically for these conditions.</b></p>	<p><b>KM-04 (1 Credit):</b> Conducts behavioral health screening and/or assessments using a standardized tool. (Implement two or more). <b>A.</b> Anxiety, <b>B.</b> Alcohol use disorder, <b>C.</b> Substance use disorder, <b>D.</b> Pediatric behavioral health screening, <b>E.</b> Post-traumatic stress disorder, <b>F.</b> Attention deficit/hyperactivity disorder, <b>G.</b> Postpartum depression</p>
<p><b>3:C:9</b> Depression screening for adults and adolescents using a standardized tool.</p>	<p><b>KM-03 (Core):</b> Conducts depression screenings for adults and adolescents using a standardized tool.</p>
<p><b>3:C:10</b> The practice assesses the patient/family/caregiver's ability to understand the concepts and care requirements associated with managing their health.</p>	<p><b>KM-08 (1 Credit):</b> Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials.</p>
<p><b>PCMH 3: Population Health Management – Use Data for Population Management (MUST-PASS), Element D</b></p>	<p><b>Matching NCQA 2017 Criteria</b></p>
<p><b>3:D: At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:</b>  <b>3:D:1</b> At least two different preventive care services  <b>3:D:2</b> At least two different immunizations  <b>3:D:3</b> At least three different chronic or acute care services  <b>3:D:4</b> Patients not recently seen by the practice</p>	<p><b>KM-12 (Core):</b> The practice proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):</p> <ul style="list-style-type: none"> <li><b>A. Preventive care services</b></li> <li><b>B. Immunizations</b></li> <li><b>C. Chronic or acute care services</b></li> <li><b>D. Patients not recently seen by the practice.</b></li> </ul>



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

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

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

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NCQA 2014, Standard 4	2017 Criteria
<p align="center"><b>PCMH 4: Care Management and Support – Support Self-Care and Shared Decision Making, Element E</b></p>	<p align="center"><b>Matching NCQA 2017 Criteria</b></p>
<p><b>The practice has, and demonstrates use of materials to support patients and families/caregivers in self-management and shared decision making. The practice</b>  <b>4:E:1</b> Uses an EMR to identify patient-specific education resources and provide them to more than 10 percent of patients.</p>	<p align="center"><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>4:E:2</b> Provides educational materials and resources to patients.</p>	<p><b>KM-22 (1 Credit):</b> Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.</p>
<p><b>4:E:3</b> Provides self-management tools to record self-care results.</p>	<p align="center"><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>4:E:4</b> Adopts shared decision making aids.</p>	<p><b>KM-24 (1 Credit):</b> Adopts shared decision-making aids for preference-sensitive conditions.</p>
<p><b>4:E:5</b> Offers or refers patients to structured health education programs, such as group classes and peer support.</p>	<p><b>KM-22 (1 Credit):</b> Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.</p>
<p><b>4:E:6</b> 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.</p>	<p><b>KM-26 (1 Credit):</b> Routinely maintains a current community resource list based on the needs identified in KM-21.</p>
<p><b>4:E:7</b> Assess usefulness of identified community resources.</p>	<p><b>KM-27 (1 Credit):</b> Assesses the usefulness of identified community support resources.</p>

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Updated 5/1/17

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

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NCQA 2014, Standard 5	2017 Criteria
5:B:3 Maintains agreements with behavioral healthcare providers.	<b>CC-09 (2 Credits):</b> Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.
5:B:4 Integrates behavioral healthcare providers within the practice site.	<b>CC-10 (2 Credits):</b> Integrates behavioral healthcare providers into the care delivery system of the practice site.
<p>5:B:5 Gives the consultant or specialist the clinical question, the required timing and the type of referral.</p> <p>5:B:6 Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.</p> <p>5:B:8 <b>(Critical Factor)</b> Tracks referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports.</p>	<b>CC-04 (Core):</b> The practice systematically manages referrals by: <b>A.</b> Giving the consultant or specialist the clinical questions, the required timing and the type of referral, <b>B.</b> Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan, <b>C.</b> Tracking referrals until the consultant or specialist’s report is available, flagging and following up on overdue reports.
5:B:7 Has the capacity for electronic exchange of key clinical information and provides an electronic summary of care record to another provider for more than 50 percent of referrals.	<b>Related to CC-21 (Maximum 3 Credits):</b> Demonstrates electronic exchange of information with external entities, agencies and registries.
5:B:9 Documents co-management arrangements in the patient’s medical record.	<b>CC-12 (1 Credit):</b> Documents co-management arrangements in the patient’s medical record.
5:B:10 Asks patients/families about self-referrals and requesting reports from clinicians.	<b>NO MATCHING 2017 CRITERIA</b>
PCMH 5: Care Coordination and Care Transitions – Coordinate Care Transitions, Element C	Matching NCQA 2017 Criteria
5:C:1 Proactively identifies patients with unplanned hospital admissions and emergency department visits.	<b>CC-14 (Core):</b> Systematically identifies patients with unplanned hospital admissions and emergency department visits.
5:C:2 Shares clinical information with admitting hospitals and emergency departments.	<b>CC-15 (Core):</b> Shares clinical information with admitting hospitals and emergency departments.
5:C:3 Consistently obtains patient discharge summaries from the hospital and other facilities.	<b>CC-19 (1 Credit):</b> Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.
5:C:4 Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.	<b>CC-16 (Core):</b> Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.

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NCQA 2014, Standard 5	2017 Criteria
<p><b>5:C:5</b> Exchanges patient information with the hospital during a patient’s hospitalization.</p>	<p><b>CC-18 (1 Credit):</b> Exchanges patient information with the hospital during a patient’s hospitalization.</p>
<p><b>5:C:6</b> Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners.</p>	<p><b>NO MATCHING 2017 CRITERIA</b></p>
<p><b>5:C:7</b> 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.</p>	<p><b>CC-21 (Maximum Credits): (C)</b> Making the summary of care record accessible to another provider or care facility for care transitions.</p>

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Updated 5/1/17

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



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

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Updated 5/1/17

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

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NCQA 2014, Standard 6	2017 Criteria
<p><b>6:G:7</b> The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically. <b>(B)</b></p> <p><b>6:G:8</b> The practice has access to a health information exchange. <b>(A)</b></p> <p><b>6:G:9</b> The practice has bidirectional exchange with a health information exchange. <b>(A)</b></p> <p><b>5:C:7</b> 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. <b>(C)</b></p>	<p><b>CC-21 (Maximum 3 Credits):</b> Demonstrates electronic exchange of information with external entities, agencies, and registries (May select one or more):</p> <ul style="list-style-type: none"> <li><b>A.</b> Regional health information organization or other health information exchange source that enhances the practice’s ability to manage complex patients. <b>(1 Credit)</b></li> <li><b>B.</b> Immunization registries or immunization information systems. <b>(1 Credit)</b></li> <li><b>C.</b> Summary of care record to another provider or care facility for care transitions. <b>(1 Credit)</b></li> </ul>
<p><b>6:G:10</b> 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. <b>(Similar to KM-12 on 2017 Standards, but not the same).</b></p>	<p><b>KM-12 (Core):</b> The practice proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):</p> <ul style="list-style-type: none"> <li><b>A. Preventive care services</b></li> <li><b>B. Immunizations</b></li> <li><b>C. Chronic or acute care services</b></li> <li><b>D. Patients not recently seen by the practice.</b></li> </ul>