# *COMPARISON*: PPC-PCMH 2008 With PCMH 2011

## About This Crosswalk

The following crosswalk compares Physician Practice Connections®—Patient-Centered Medical Home™ (PPC®-PCMH™) 2008 with NCQA's Patient-Centered Medical Home (PCMH) 2011.

*The left column* lists the PPC-PCMH 2008 standards, elements and other content that was deleted or was changed significantly in the PCMH 2011 standards.

*The right column* lists standards, elements and other content that is significantly different from with PPC-PCMH 2008.

***Note:*** *The crosswalk does not compare PPC-PCMH 2008 with PCMH 2011 at the factor level.*

## PCMH 2011 Definitions

**Must-pass element**

- Identifies critical concepts of PCMH
- Helps focus Level 1 practices on most important aspects of PCMH
- Guides practices in PCMH evolution and continuous quality improvement
- Standardizes "Recognition"

**Critical factor**

- Required for practices to receive more than minimal or, for some factors, any points.
- Identified in the scoring section of the element

| ***DELETED ITEMS:* PPC-PCMH 2008** | **Points** | ***KEY CHANGES:* PCMH 2011** | **Points** |
|---|---|---|---|
| **PPC 1: Access and Communication** | **9** | **PCMH 1: Enhance Access and Continuity** | **20** |
| **PPC 1A: Access and Communication Processes—*MUST PASS***<br>*Deleted:*<br>• Appointments based on patient request<br>• Appointments based on triage<br>• Appointments coordinating visits with multiple clinicians/diagnostic tests | **4** | **PCMH 1A: Access During Office Hours—*MUST PASS***<br>• Includes access during office hours using several venues<br>• Requires documentation of process AND implementation<br>• Requires availability of same day appointments *(CRITICAL FACTOR)*<br>• Requires documentation of clinical advice in patient record<br>• Includes items from PPC 1A and 1B | **4** |
| **PPC 1B: Access and Communication Results—*MUST PASS***<br>*Changed:*<br>• PPC 1B required documentation of policies identified in PPC1A.<br>• Now PCMH 1A and 1B require both policy <u>and</u> documentation of policies in each element | **5** | **PCMH 1B:After-Hours Access**<br>• Includes after-hours access<br>• Requires documentation of process AND implementation<br>• Encourages appointments outside regular business hours<br>• Requires availability of advice after hours *(CRITICAL FACTOR)*<br>• Requires documentation of after-hours care and clinical advice in medial record<br>• Includes items from PPC 1A and 1B | **4** |
| | | **PCMH 1C: Electronic Access**<br>• Asks practice to provide e-copy of health information, access to current health information and clinical summary of office visits<br>• Includes some items from PPC, 9B, 9C | **2** |
| | | **PCMH 1D: Continuity**<br>• Asks practice to have a documented process and materials to encourage patient selection of clinician<br>• Includes items from PPC 1A and 1B | **2** |
| | | **PCMH 1E: Medical Home Responsibilities**<br>• New<br>• Requires practice to have a process and materials to explain role of medical home (practice and patient/family responsibilities) | **2** |
| | | **PCMH 1F: Culturally and Linguistically Appropriate Services (CLAS)**<br>• New<br>• Expands requirements for CLAS<br>• Includes some items from elements PPC 1A and 4A related to language needs of patients and provision of materials in patient language | **2** |
| | | **PCMH 1G: The Practice Team**<br>• Requires practice to have daily team communication, e.g. team huddle *(CRITICAL FACTOR)*<br>• Provides team training on communication skills, population management, self-management support<br>• Asks practice to include team in quality improvement activities<br>• Includes some items from PPC 3C | **4** |

| ***DELETED ITEMS:*** **PPC-PCMH 2008** | **Points** | ***KEY CHANGES:*** **PCMH 2011** | **Points** |
|---|---|---|---|
| **PPC 2: Patient Tracking and Registry** | **21** | **PCMH 2: Identify and Manage Patient Populations** | **16** |
| **PPC 2A: Basic System for Managing Patient Data**<br>• Deleted name, marital status, address, internal and external IDs, emergency contacts, billing codes for services | **2** | **PCMH 2A: Patient Information** | **3** |
| **PPC 2B: Electronic System for Clinical Data** | **3** | **PCMH 2B: Clinical Data**<br>• Requires a report (2011) rather than a chart review (2008)<br>• Includes items from PPC 2B, 2C, 2D, 3B | **4** |
| **PPC 2C: Use of Electronic Clinical Data**<br>• Moved items to PCMH 2B | **3** | | |
| **PPC 2D: Organizing Clinical Data—*MUST PASS***<br>• Moved items to PCMH 2B and 2C | **6** | | |
| | | **PCMH 2C: Comprehensive Health Assessment**<br>• New<br>• Includes some items from PPC 2E, 3B and 4A<br>• Health risk items are not population-based as they were in PPC 2E; instead are patient-specific | **4** |
| **PPC 2E: Identifying Important Conditions—*MUST PASS***<br>• Moved identification of important conditions to PCMH 3A<br>• Deleted practice's most frequently seen diagnoses and most important risk factors in the practice's population | **4** | | |
| **PPC 2F: Use of System for Population Management** | **3** | **PCMH 2D: Use Data for Population Management—MUST PASS**<br>• Asks practice to identify patients not recently seen by practice<br>• Requires three (3) preventive care services instead of one (1) (2008)<br>• Requires three (3) chronic care services instead of one (1) (2008)<br>• Includes preventive service reminders from PPC 3B | **5** |
| **PPC 3: Care Management** | **20** | **PCMH 3: Plan and Manage Care** | **17** |
| **PPC 3A: Guidelines for Important Conditions—*MUST PASS*** | **3** | **PCMH 3A: Implement Evidence-Based Guidelines**<br>• New: Third important condition must be unhealthy behavior, mental health or substance abuse *(CRITICAL FACTOR)* | **4** |
| **PPC 3B: Preventive Service Clinician Reminders**<br>• Moved items to PCMH 2C, 2D | **4** | | |
| | | **PCMH 3B: Identify High-Risk Patients**<br>• New<br>• Requires practice to Identify high risk/complex patients and calculate percent of total patient population | **3** |

| *DELETED ITEMS:* PPC-PCMH 2008 | Points | *KEY CHANGES:* PCMH 2011 | Points |
|---|---|---|---|
| **PPC 3: Care Management** | **20** | **PCMH 3: Plan and Manage Care** | **17** |
| **PPC 3C: Practice Organization**<br>• Moved items to PCMH 1G | **3** | | |
| **PPC 3D: Care Management of Important Conditions** | **5** | **PCMH 3C: Care Management—*MUST PASS***<br>• Includes high-risk patients<br>• Record review increased from 36 to 48 patients<br>• Includes requirement for practice to provide patient/family with clinical summary of visit | **4** |
| | | **PCMH 3D: Medication Management**<br>• Asks the practice to track patient medications by:<br>– Reconciling medications at care transitions, relevant visits or at least annually *(CRITICAL FACTOR)*<br>– Providing information to patients about new prescriptions<br>– Assessing patient/family understanding of and response to medications<br>– Assessing barriers to adherence<br>• Asks practice to document over-the-counter medications, herbal therapies and supplements<br>• Includes some items from PPC 2D and 3D | **3** |
| | | **PCMH 3E: Use Electronic Prescribing**<br>• Asks practices to integrate E-prescriptions into patient record<br>• Includes items from PPC 5A, 5B, 5C<br>• Generates prescriptions electronically *(CRITICAL FACTOR)* | **3** |
| **PPC3E: Continuity of Care**<br>• Moved coordination of care with facilities items to PCMH 5C | **5** | | |
| **PPC4: Patient Self-Management** | **6** | **PCMH 4: Provide Self-Care Support and Community Resources** | **9** |
| **PPC4A: Documenting Communication Needs**<br>• Moved communication needs to PCMH 2A and 1F | **2** | | |
| **PPC4B: Self-Management Support—*MUST PASS***<br>• Deleted readiness to change<br>• Moved educational resource in patient language to PCMH 1F | **4** | **PCMH 4A: Support Self-Care Process—*MUST PASS***<br>• Asks practice to counsel patients to adopt healthy behaviors<br>• Requires practice to develop and document self-management plans/goals *(CRITICAL FACTOR)*<br>• Requires electronic search to identify education resources<br>• Includes some items from PPC 4B and 9C | **6** |

| *DELETED ITEMS:* PPC-PCMH 2008 | Points | *KEY CHANGES:* PCMH 2011 | Points |
|---|---|---|---|
| **PPC4: Patient Self-Management** | **6** | **PCMH 4: Provide Self-Care Support and Community Resources** | **9** |
| | | **PCMH4B: Provide Referrals to Community Resources**<br>• New<br>• Requires practice to develop resource list on five key topics/key services of importance to patient population and to track referrals<br>• Asks practice to arrange for or provide treatment for mental health and substance abuse disorders<br>• Offers opportunities for health education programs | **3** |
| **PPC 5: Electronic Prescribing** | **8** | **PCMH 5: Track and Coordinate Care** | **18** |
| **PPC 5A: Electronic Prescription Writing**<br>• Moved items to PCMH 3E<br>• Deleted inquiry about type of electronic prescription writer | **3** | | |
| **PPC 5B: Prescribing Decision Support—Safety**<br>• Moved items to PCMH 3E<br>• Deleted items related to general information (e.g., drug-drug, drug-disease general interactions, drug-allergy, drug-patient general alerts, duplication of drugs, drugs to avoid in the elderly) | **3** | | |
| **PPC 5C: Prescribing Decision Support—Efficiency**<br>• Moved items to PCMH 3E | **2** | | |
| | | **PCMH 5A: Test Tracking and Follow-Up**<br>• Track, flag and follow-up on lab and imaging *(CRITICAL FACTORS)*<br>• Electronic ordering and retrieval of test results into the EHR<br>• Includes items from PPC 6A, 6B | **6** |
| | | **PCMH 5B: Referral Tracking and Follow-Up—MUST PASS**<br>• More specifics about tracking and following up on referrals<br>• Ask patient about self-referrals and document in the record<br>• Establish agreements with specialists<br>• Electronic communication with specialists<br>• Includes items from PPC 7A and 9C | **6** |
| | | **PCMH 5C: Coordinate With Facilities/Care Transitions**<br>• Process for information exchange during patient hospitalization and with facilities<br>• Capability to provides an electronic summary of care for care transitions<br>• Includes items from PPC 3C | **6** |

| *DELETED ITEMS:* PPC-PCMH 2008 | Points | *KEY CHANGES:* PCMH 2011 | Points |
|---|---|---|---|
| **PPC 6: Test Tracking** | **13** | | |
| **PPC 6A: Test Tracking and Follow-Up—*MUST PASS***<br>• Moved items to PCMH 5A | **7** | | |
| **PPC 6B: Electronic System for Managing Tests**<br>• Moved items to PCMH 5A | **6** | | |
| **PPC 7: Referral Tracking** | **4** | | |
| **PPC 7A: Referral Tracking and Coordination—*MUST PASS***<br>• Moved items to PCMH 5B | **4** | | |
| **PPC 8: Performance Reporting and Improvement** | **15** | **PCMH 6: Measure and Improve Performance** | **20** |
| **PPC 8A: Measures of Performance—*MUST PASS***<br>• Moved items to PCMH 6A | **3** | **PCMH 6A: Measure Performance**<br>• Requirements increased to 3 preventive and 3 chronic care measures<br>• New: Data includes 2 utilization measures affecting health care costs<br>• New: Stratify data by vulnerable populations | **4** |
| **PPC 8B: Patient Experience Data**<br>• PPC 8B items moved to PCMH 6B | **3** | **PCMH 6B: Measure Patient/Family Experience**<br>• New categories of measurement: coordination, whole person care/self-management support<br>• May use Patient-Centered Medical Home CAHPS-CG survey questions which will be available late summer 2011 | **4** |
| **PPC 8C: Reporting to Physicians—*MUST PASS***<br>• PPC 8C items moved to PCMH 6E | **3** | | |
| **PPC 8D: Setting Goals and Taking Action** | **3** | **PCMH 6C: Implement Continuous Quality Improvement—*MUST PASS***<br>• Includes evaluation of disparities in care<br>• Increased the number of measures practice required to track<br>• Practices are asked to include patients on their QI team or practice advisory council | **4** |
| | | **PCMH 6D: Demonstrate Continuous Quality Improvement**<br>• New<br>• Emphasizes evaluation quality improvement by tracking results over time | **3** |
| **PPC 8E: Reporting Standardized Measures** | **2** | **PCMH 6E: Report Performance**<br>• Adds credit for reporting externally to patients or publically<br>• Includes items from PPC 8C | **3** |
| **PPC 8F: Electronic Reporting—External Entities** | **1** | **PCMH 6F: Report Data Externally**<br>• New: Specific to Meaningful Use<br>• Report ambulatory clinical quality data, immunization data to registries/systems, syndromic surveillance data | **2** |

| *DELETED ITEMS:* PPC-PCMH 2008 | Points | *KEY CHANGES:* PCMH 2011 | Points |
|---|---|---|---|
| **PPC 8: Performance Reporting and Improvement** | **15** | **PCMH 6: Measure and Improve Performance** | **20** |
| | | **PCMH 6G: Use Certified EHR Technology**<br>• New: Specific to Meaningful Use<br>• Use of EHR certified EHR that is issued a Certified HIT Products List (CHPL) Number(s)<br>• Attestation to conducting a security risk analysis of EHR, implementing security updates and correcting security deficiencies | **0** |
| **PPC 9: Advanced Electronic Communication** | **4** | | |
| **PPC 9A: Availability of Interactive Web**<br>• Moved items to PCMH 1C | **1** | | |
| **PPC 9B: Electronic Patient Identification**<br>• Moved items to PCMH 1C | **2** | | |
| **PPC 9C: Electronic Care Management Support**<br>• Moved items to PCMH 1C | **1** | | |

# PPC-PCMH 2008—PCMH 2011 Summary of Changes

| STRUCTURE AND SCORING OVERVIEW | |
|---|---|
| **PPC-PCMH 2008** | **PCMH 2011** |
| • 100 points<br>• 9 standards, 30 elements<br>• 3 levels<br>– Level 1: 25-49 points, 5 of 10 Must Pass<br>– Level 2: 50-74 points, 10 of 10 Must Pass<br>• Level 3: 75-100 points, 10 of 10 Must Pass 100 points | • 100 points<br>• 6 standards, 27 elements<br>• 3 Levels<br>– Level 1: 35-59 points, 6 of 6 Must Pass<br>– Level 2: 60-84 points, 6 of 6 Must Pass<br>– Level 3: 85-100 points, 6 of 6 Must Pass<br>• Includes Critical Factors:<br>– Central to a medical home practice<br>– Required for minimal/any points<br>• Embedded CMS Meaningful Use Requirements |
| **PCMH 2011 CHANGES** | |
| 1. Enhances patient/family-centeredness and care coordination<br>2. Emphasizes language, culturally sensitive aspects of care<br>3. Integrates behaviors affecting health, substance abuse, mental health and risk factor assessment and management<br>4. Enhances applicability to pediatric practices<br>5. Aligns with CMS Meaningful Use requirements<br>6. Targets high-risk/complex patients for care management<br>7. Emphasizes relationship with/expectations of specialists | 1. Enhances evaluation of patient experience<br>2. Underscores the importance of system cost-savings<br>3. Enhances use of clinical performance measures and patient experience results<br>4. Emphasizes continuous quality improvement<br>5. Promotes electronic communication with patients/families<br>6. Emphasizes team-based care<br>7. Increased reports requiring numerator/denominator<br>8. More detailed explanations and documentation descriptions |

| 2011 OPTIONAL PATIENT EXPERIENCE SURVEY<br>*Patient-Centered Medical Home (PCMH) CAHPS-Clinician Group* | |
|---|---|
| • Optional Patient-Centered Medical Home CAHPS-CG survey will be available late summer 2011<br>• Data may be submitted to NCQA early in 2012 using a specified methodology | • Data will be used for additional practice acknowledgement and national benchmarking |