TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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Core Attribute #1: Access to Care ***"Health care team, be there when we need you."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
1.A) Timely Access and Communication	N/A	**1.A.1** PCPCH regularly tracks timely access and communication to clinical staff and care teams.	**1.A.2** PCPCH regularly tracks timely access and communication to clinical staff and care teams, and either meets specific targets or has implemented an improvement plan to improve outcomes.	
1.B) After Hours Access	N/A	**1.B.1** PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	N/A	N/A
1.C) Telephone Access	**1.C.0** PCPCH assures that its patients have continuous access to clinical advice by telephone.	**1.C.1** PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.	N/A	N/A
1.D) Same Day Access	N/A	**1.D.1** PCPCH provides same day appointments.	N/A	N/A
1.E) Electronic Access	N/A	**1.E.1** PCPCH regularly communicates with patients through a patient portal.	**1.E.2** PCPCH provides patients with access to an electronic copy of their health information in an accessible format.	N/A
1.F) Prescription Refills	N/A	N/A	**1.F.2** PCPCH tracks the time to completion for prescription refills.	**1.F.3** PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.
1.G) Alternative Access	N/A	**1.G.1** PCPCH offers telehealth services to its patients in their	**1.G.2** PCPCH offers at least one alternative visit type to	**1.G.3** PCPCH regularly provides patient care in community-based settings.

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		primary language.	its patients and can demonstrate that it improves access.	

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Core Attribute #2: Accountability ***"Take responsibility for making sure we receive the best possible health care."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
2.A) Performance and Clinical Quality	**2.A.0** PCPCH tracks and reports to OHA three primary care quality measures.	**2.A.1** PCPCH tracks and reports to OHA disparities in three primary care quality measures.	**2.A.2** PCPCH tracks, reports to OHA, and demonstrates a combination of improvement and meeting benchmarks on three primary care quality measures. (D)	**2.A.3** PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures. (D)
2.B) Value-based Payment	N/A	**2.B.1** PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with one payer.	**2.B.2** PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	**2.B.3** PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 3A or higher with at least two payers or with one payer that covers a portion of the practice's patient population.
2.C) Patient and Family Involvement in Quality Improvement	N/A	**2.C.1** PCPCH involves patients, families, and caregivers, as advisors on at least one quality or safety Initiative per year.	**2.C.2** PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development or educational improvement activities.	**2.C.3** Patient, family, and caregiver - advisors are integrated into the PCPCH and function in peer support or training roles.

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TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #2: Accountability (continued) ***"Take responsibility for making sure we receive the best possible health care."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
2.D) Quality Improvement	N/A	**2.D.1** PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	**2.D.2** PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project, and documents their progress.	**2.D.3** PCPCH has a documented clinic-wide improvement strategy with performance goals derived from patient, family, caregiver and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.
2.E) Ambulatory Sensitive Utilization	N/A	N/A	**2.E.2** PCPCH identifies patients experiencing unplanned or adverse patterns in at least one utilization measure and contacts patients, families, or caregivers for follow-up care.	**2.E.3** PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families, or caregivers for follow-up care.
2.F) PCPCH Staff Vitality	N/A	**2.F.1** PCPCH develops and implements a strategy to improve the vitality of its staff.	**2.F.2** PCPCH develops, implements, and evaluates a strategy to improve the vitality of their staff.	N/A

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Core Attribute #3: Comprehensive Whole Person Care ***"Provide or help us get the health care, information, and services we need."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
3.A) Preventive Services	N/A	**3.A.1** PCPCH routinely offers or coordinates recommended age and sex-specific preventive services for its patient population based on best available evidence and identifies areas for improvement.	**3.A.2** PCPCH routinely offers or coordinates recommended age and sex-specific preventive services for its patient population and has an improvement strategy in effect to address gaps in preventive service offerings as appropriate for its patient population.	**3.A.3** PCPCH routinely offers or coordinates 90% of all recommended age and sex-specific preventive services.
3.B) Medical Services	**3.B.0** PCPCH routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.	N/A	N/A	N/A
3.C) Behavioral Health Services	**3.C.0** PCPCH has a routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.	N/A	**3.C.2.a** PCPCH collaborates or is co-located, and coordinates care, with specialty mental health, substance use disorder, and developmental providers. **3.C.2.b** PCPCH provides pharmacotherapy to patients with	**3.C.3** PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers

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			substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	

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Core Attribute #3: Comprehensive Whole Person Care (Continued) ***"Provide or help us get the health care, information, and services we need."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
3.D) Health Related Social Needs	N/A	N/A	**3.D.2** PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.	**3.D.3** PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.
3.E) Preventive Services Reminders	N/A	**3.E.1** PCPCH generates lists of patients who need reminders for preventive services and ensures that they are sent appropriate reminders.	**3.E.2** PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services.	**3.E.3** PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach

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				strategy.
3.F) Oral Health Services	N/A	**3.F.1** PCPCH screens or assesses its patients for oral health needs.	**3.F.2** PCPCH screens or assesses its patients for oral health needs and provides age-appropriate interventions.	**3.F.3** PCPCH provides oral health services by dental providers.

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Core Attribute #4: Continuity **"Be our partner over time in caring for us."**				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
4.A) Personal Clinician Assignments and Continuity	**4.A.0** PCPCH reports the percent of active patients assigned to a personal clinician or team and has a process for considering patient choice in assignment. PCPCH also reports the percent of visits in which a patient saw their assigned clinician or team. (D)	N/A	**4.A.2** PCPCH tracks and improves the percent of visits in which a patient saw their assigned clinician or team. (D)	**4.A.3** PCPCH meets a benchmark for the percent of visits in which a patient saw their assigned clinician or team. (D)
4.B) Medication Reconciliation and Management	N/A	N/A	**4.B.2** PCPCH provides medication reconciliation and medication management for its patients.	**4.B.3** PCPCH provides medication management for its patients by a pharmacist.

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4.C) Organization of Clinical Information	**4.C.0** PCPCH uses an electronic health record (EHR) technology that is certified by the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.	**4.C.1** PCPCH documents its patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record.	**4.C.2** PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.	N/A

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Core Attribute #4: Continuity (Continued) **"Be our partner over time in caring for us."**				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
4.D) Clinical Information Exchange	N/A	N/A	**4.D.2** PCPCH exchanges clinical information electronically with another provider or setting of care.	**4.D.3** PCPCH shares clinical information electronically in real time with other providers and care entities through an electronic health information exchange.
4.E) Hospital Setting Transitions	**4.E.0** PCPCH has a documented process for transitions of care with its usual hospital providers or	N/A	**4.E.2** PCPCH has a process for following up with its patients post-discharge from the hospital and emergency department.	N/A

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	directly provides routine hospital care.			
4.F) Planning for Continuity	**4.F.0** PCPCH has a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available.	N/A	N/A	N/A

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Core Attribute #5: Coordination and Integration ***"Help us navigate the health care system to get the care we need in a safe and timely way."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
5.A) Population Data Management	N/A	**5.A.1** PCPCH uses data on its entire patient population to track overall health needs or engage in proactive patient population management.	**5.A.2** PCPCH stratifies its entire patient population according to health risk.	**5.A.3** PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category.
5.B) Health Care Cost Navigation	N/A	**5.B.1** PCPCH informs its patients of preventive services that do not require cost-sharing.	N/A	**5.B.3** PCPCH assists its patients in navigating the cost and payment options for their care.
5.C) Complex Care Coordination	N/A	**5.C.1** PCPCH assigns care coordination responsibilities to specific practice staff and informs patients, families, and caregivers on how to access care coordination services.	**5.C.2** PCPCH identifies patients with complex care needs and coordinates their care.	**5.C.3** PCPCH collaborates with patients, families, or caregivers to develop individualized and culturally appropriate written care plans for complex medical or social concerns.

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Core Attribute #5: Coordination & Integration (Continued) ***"Help us navigate the health care system to get the care we need in a safe and timely way."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
5.D) Test & Result Tracking	N/A	**5.D.1** PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification and explanation of results to patients, families, or caregivers as well as to ordering clinicians.	N/A	N/A
5.E) Referral and Care Coordination with Specialists, Care Facilities, and Governmental Systems	N/A	**5.E.1** PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians.	**5.E.2** PCPCH coordinates care when its patients receive care in specialized settings such as hospitals, skilled nursing or other long-term care facilities, and in-patient behavioral health facilities.	**5.E.3** PCPCH coordinates care for its patients who are engaged with or receiving services from the Oregon Department of Human Services, criminal justice, education, or public health systems.
5.F) End of Life Planning	**5.F.0** PCPCH has a process for offering or coordinating hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	**5.F.1** PCPCH has a process for engaging patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care.	N/A	N/A

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Core Attribute #6: Person- and Family-Centered Care ***"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
6.A) Meeting Language and Health Literacy	**6.A.0** PCPCH offers time-of-service interpretation to communicate with patients,	**6.A.1** PCPCH provides written patient materials in languages other than English.	**6.A.2** PCPCH assures that patient communications and materials are at an appropriate health literacy	N/A

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Needs	families, or caregivers in their primary language.		level.	
6.B) Education and Self-Management Support	N/A	**6.B.1** PCPCH provides culturally and linguistically appropriate patient-specific education resources to its patient population.	**6.B.2** provides culturally and linguistically appropriate patient-specific education resources and offers or connects patients, families, and caregivers with self-management support resources	N/A
6.C) Experience of Care	**6.C.0** PCPCH surveys a sample of its population on their experiences with specific areas of care and shares results with clinic staff. PCPCH also meets a survey completion benchmark or has a strategy to increase the number of surveys completed.	**6.C.1** PCPCH surveys a sample of its population on their experiences with specific areas of care and demonstrates the utilization of survey data in quality improvement activities.	**6.C.2** PCPCH surveys a sample of its population on their experiences with specific areas of care, including health equity, and demonstrates the utilization of survey data in quality improvement activities.	N/A
Core Attribute #6: Person- and Family-Centered Care (Continued) ***"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."***				
Standard	**Must-Pass ✓**	**5 points each**	**10 points each**	**15 points each**
6.D) Communication of Rights, Roles, and Responsibilities	**6.D.0** PCPCH has a written document or other educational materials that outlines PCPCH and patient rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.	N/A	N/A	N/A
6.E) Cultural Responsiveness of	**6.E.0** PCPCH assures that its staff is trained in delivering	N/A	N/A	**6.E.3** PCPCH partners with one or more traditional

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Workforce	culturally and linguistically appropriate, trauma-informed, or trust-building care.			health workers or traditional health worker services.

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