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) In-Person Access	N/A	**1.A.1** PCPCH surveys a sample of its population on satisfaction with in-person access to care. (A)	**1.A.2** PCPCH surveys a sample of its population using one of the Consumer Assessment of Health-care Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care. (A)[1]	**1.A.3** PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care. (A)
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. (A)[2]	N/A	N/A
1.C) Telephone & Electronic Access	**1.C.0** PCPCH provides continuous access to clinical advice by telephone. (A)	N/A	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 provides patients with an electronic copy of their health information upon request using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. (A)	N/A	N/A
1.F) Prescription Refills	N/A	N/A	**1.F.2** PCPCH tracks the time to completion for prescription refills. (A)[3]	**1.F.3** PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription. (A)

(A)= Attestation (D) = Data must be submitted

[1] Acceptable CAHPS survey tools include the Health Plan and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.
[2] Traditional business hours are defined as 8am-5pm
[3] Please see technical specifications for more details, but refills are considered complete when they have been signed.

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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 & Clinical Quality	**2.A.0** PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures. (A)[4]	**2.A.1** PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D)[5]	**2.A.2** PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D)	**2.A.3** PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D) [4]
2.B) Public Reporting	N/A	**2.B.1** PCPCH participates in a public reporting program for performance indicators. (A)	**2.B.2** Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes . (A)	N/A
2.C) Patient and Family Involvement in Quality Improvement	N/A	**2.C.1** PCPCH involves patients, caregivers, and patient-defined families as advisors at least one quality or safety Initiative per year. (A)	**2C.2** PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development or educational improvement activities. (A)	**2.C.3** Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles. (A)

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[4] See Table 2 for the list of PCPCH Quality Measures. Details about the core and menu set, along with technical specifications for all measures are available on the program website.

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. (A)	**2.D.2** PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress. (A)	**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. (A)
2.E) Ambulatory Sensitive Utilization	N/A	**2.E.1** PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population. (A)	**2.E.2** PCPCH tracks selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization.(A)	**2.E.3** PCPCH tracks selected utilization measures and shows improvement or meets a benchmark on selected utilization measures. (A)

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TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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 preventive services appropriate for your population (i.e. age and gender) based on best available evidence and identifies areas for improvement. (A)	**3.A.2** PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population. (A)	**3.A.3** PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services. (A)
3.B) Medical Services	**3.B.0** PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support. (A)	N/A	N/A	N/A
3.C) Behavioral Health Services[5]	**3.C.0** PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes (A) .	N/A	**3.C.2** PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers (A) .	**3.C.3** PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers (A).

(A)= Attestation (D) = Data must be submitted

[5] A PCPCH can earn points for both 3.C.2 and 3.C.3 for this standard if applicable (check all that apply).

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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) Comprehensive Health Assessment & Intervention	N/A	**3.D.1** PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors. (A)	N/A	N/A
3.E) Preventive Services Reminders	N/A	**3.E.1** PCPCH sends reminders to patients for preventative/follow-up care using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. (A).	**3.E.2** PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders. (A)	**3.E.3** PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services. (A)

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TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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 Assigned	**4.A.0** PCPCH reports the percentage of active patients assigned a personal clinician or team. (D)	N/A	N/A	**4.A.3** PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)
4.B) Personal Clinician Continuity	**4.B.0** PCPCH reports the percent of patient visits with assigned clinician-or team. (D)	N/A	**4.B.2** PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	**4.B.3** PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)
4.C) Organization of Clinical Information	**4.C.0** PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit. (A)	N/A	N/A	N/A

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TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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	N/A	**4.D.3** PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). (A)
4.E) Specialized Care Setting Transitions	**4.E.0** PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (A)	N/A	N/A	N/A
4.F) Planning for Continuity	N/A	**4.F.1** PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.(A)	N/A	N/A
4.G) Medication Reconciliation	N/A	**4.G.1** Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation using a method that satisfies either Stage 1 or Stage 2 meaningful use measures (A).	**4.G.2** PCPCH develops a process, tracks and reports the percentage of patients whose medication regimen is reconciled at each relevant patient encounter (A).	**4.G.3** PCPCH provides Comprehensive Medication Management for appropriate patients and families (A).

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TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #5: Coordination & 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 [6]	N/A	**5.A.1** PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its patient population, including the identification of sub-populations (A).	**5.A.2** PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior (A).	N/A
5.B) Electronic Health Record	N/A	N/A	N/A	**5.B.3** PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be "meaningful users" of certified electronic health record technology established by the Centers for Medicare and Medicaid Services. (A)
5.C) Complex Care Coordination[7]	N/A	**5.C.1** PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member responsible for coordinating his or her care. (A)	**5.C.2** PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (A)	**5.C.3** PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self-management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness. (A)

(A)= Attestation (D) = Data must be submitted

[6] A PCPCH can earn points for 5.A.1 and 5.A.2 on this standard if applicable (check all that apply).
[7] A PCPCH can earn points for 5.C.1, 5.C.2, and 5.C.3 on this standard if applicable (check all that apply).

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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 or availability of results to patients and families with interpretation, as well as to ordering clinicians. (A)	N/A	N/A
5.E) Referral & Specialty Care Coordination[8]	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 or caregivers and clinicians.(A)	**5.E.2** PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility). (A)	**5.E.3** PCPCH tracks referrals- and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services. (A)
5.F) End of Life Planning	**5.F.0** PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (A)	**5.F.1** PCPCH has a process to engage 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; forms are submitted to available registries (unless patient opts out). (A)	N/A	N/A

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[8] A PCPCH can earn points for 5.E.1, 5.E.2, and 5.E.3 on this standard if applicable (check all that apply).

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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) Language / Cultural Interpretation	**6.A.0** PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice. (A)	**6.A.1** PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population (A).	N/A	N/A
6.B) Education & Self-Management Support	N/A	**6.B.1** PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate (A).	**6.B.2** More than 10% of unique patients are provided patient-specific education resources (A).	**6.B.3** More than 10% of unique patients are provided patient-specific education resources and self-management services (A).
6.C) Experience of Care	**6.C.0** PCPCH surveys a sample of its patients and families at least every two years on their experience of care. The patient survey must include questions on access to care, provider or health team communica-tion, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools (A).	N/A	**6.C.2** PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process (A)	**6.C.3** PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process and meets benchmarks on the majority of the domains. (A)

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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	N/A	**6.D.1** PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, complaint, and grievance procedures; roles and responsibilities ; and has a system to ensure that each patient or family receives this information at the onset of the care relationship. (A)	N/A	N/A

(A)= Attestation (D) = Data must be submitted

Table 2. PCPCH Quality Measures

Adult Core Quality Measure Set			
Measure #	**Source**	**Measure**	**Benchmark**
1	National Quality Forum[10] (NQF) 0421	BMI Screening and Follow-up	47%
2	NQF0028	Tobacco Use: Screening and Cessation Intervention	93%
3	NQF0509	Reminder System for Mammograms	TBD
4	NQF0032	Cervical cancer screening	73%
5	OHA State Performance Measure (NQF 0034)	Colorectal cancer screening	TBD
6	OHA State Performance Measure (NQF 0057)	Comprehensive Diabetes Care: Hemoglobin A1c testing	86%
7	NQF0575	Comprehensive Diabetes Care: HbA1c control	60%
8	OHA State Performance Measure (NQF 0018)	Controlling High Blood Pressure	64%
Pediatric Core Quality Measure Set			
9	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	43%
10	OHA State Performance Measure (NQF0038)	Childhood Immunization Status	82%
11	NQF0036	Use of Appropriate Medications for People with Asthma	91%
12	OHA State Performance Measure (NQF1399)	Developmental screening in the first 3 years of life	50%
13	OHA State Performance Measure (CHIPRA Core Measure #10)	Well child care (0 – 15 months)	77%
14	CHIPRA Core Set Measure #11	Well child care (3 – 6 years)	74%

Table 2. PCPCH Quality Measures

Menu Quality Measure Set			
Measure #	**Source**	**Measure**	**Benchmark**
15	OHA State Performance Measure (CHIPRA Core Measure #12)	Adolescent well-care (12-21 years)	53%
16	OHA State Performance Measure (NQF 0418)	Screening for clinical depression	TBD
17	OHA State Performance Measure (NQF 1517)	Prenatal and Postpartum Care – Prenatal Care Rate	69%
18	OHA State Performance Measure (NQF1517)	Prenatal and Postpartum Care – Postpartum Care Rate	66%
19	OHA State Performance Measure (NQF0002)	Appropriate testing for children with pharyngitis	76%
20	NQF0043	Pneumonia vaccination status for older adults	TBD
21	NQF0044	Pneumonia Vaccination	TBD
22	NQF0041	Influenza Immunization	TBD
23	NQF0066, 67,70, 74	Chronic Stable Coronary Disease	NQF 0070, 83%
24	OHA State Performance Measure	Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse	13%
25	NQF0061	Comprehensive Diabetes Care: Blood Pressure Control	67
26	NQF0064	Comprehensive Diabetes Care: LCL-C Control	40
27	OHA State Performance Measure (NQF0108)	Follow-up care for children prescribed ADHD medication	Initiation: 51% Continuation & Maintenance: 63%
28	OHA State Performance Measure (CHIPRA Core Measure #6)	Adolescent immunizations up to date at 13 years old	70%
29	OHA State Performance Measure (NQF0063)	Comprehensive Diabetes Care: Lipid LDL-C Screening	80%

Table 3. Oregon PCPCH Program and 2011 and 2014 NCQA Recognition Requirements

Table 3 Oregon PCPCH Program and 2011 and 2014 NCQA Recognition Requirements

For practices that are recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home

Requirement	Oregon PCPCH Tier Recognition				
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**
2011 or 2014 Level 1 NCQA PCMH Recognition	Attests and provides evidence of recognition to OHA	N/A	N/A	N/A	N/A
2011 or 2014 Level 2 NCQA Recognition	N/A	Attests and provides evidence of recognition to OHA	N/A	N/A	N/A
2011 or 2014 Level 3 NCQA Recognition	N/A	N/A	Attests and provides evidence of recognition to OHA	N/A	N/A
PCPCH Performance & Clinical Quality Standard 2.A	**2.A.0** PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures	**2.A.2** PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures	**2.A.3** PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures	N/A	N/A
PCPCH Coordination and Integration Standard 5.F	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0
Submission of PCPCH recognition application to Oregon Health Authority	Optional	Optional	Optional	Attests to PCPCH measures per OAR 409-055-0040 (4)(d).	Attests to PCPCH measures per OAR 409-055-0045.

Table 4. Required PCPCH Measures for 5 STAR designation

Practices seeking 5 STAR designation must attest to 11 of the 13 PCPCH measures listed.

PCPCH Measure
1.B.1) After Hours Access
2.D.3) Quality Improvement
3.C.2) Referral Process or Co-location with Mental Health, Substance Abuse and Developmental Providers
3.C.3) Integrated Behavioral Health Services
4.B.3) Personal Clinician Continuity
5.C.1) Defined Roles in Care Coordination
5.C.2) Coordination of Care
5.C.3) Individualized Care Plan
5.E.1) Referral Tracking For Specialty Care
5.E.2) Coordination with Specialty Care
5.E.3) Cooperation with Community Service Providers
6.A.1) Language/Cultural Interpretation
6.C.2/6.C.3) Experience of Care