Office for
Oregon Health Policy and Research
Patient-Centered Primary Care Home Program

Oregon Patient-Centered Primary Care Home Model

Implementation Reference Guide
August 2011

Oregon Health Authority

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Introduction

The Patient Centered Primary Care Home (PCPCH) is a model of primary care that has received attention in Oregon and across the country for its potential to advance the "triple aim" goals of health reform: a healthy population, extraordinary patient care for everyone, and reasonable costs, shared by all. PCPCHs achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient and family-centered approach to all aspects of care. PCPCHs emphasize whole-person care in order to address a patient and family's physical and behavioral health care needs.

During the 2009 legislative session, the Oregon Legislature enacted House Bill 2009, which created the Oregon Health Authority (OHA), the Oregon Health Policy Board (OHPB), and established a PCPCH Program within the Office for Oregon Health Policy and Research (OHPR). The goals of the program are to develop strategies to identify and measure PCPCHs, promote their development, and encourage people covered by the Oregon Health Authority (OHA) to receive care in this new model.

The model described in this implementation guide is based on the work of the PCPCH Standards and PCPCH Pediatric Standards Advisory Committees, diverse groups of Oregon stakeholders including patients, clinicians, health plans/carriers and payors. In developing the Oregon PCPCH model, a concerted effort was made to draw on existing national and state primary care/medical home frameworks. However, the PCPCH Standards Advisory Committee felt strongly that existing models did not directly address health outcomes and did not sufficiently address a few specific areas of care.

The Oregon PCPCH model is defined by six Core Attributes (Access to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration, and Person and Family-Centered Care) and a number of standards and measures that describe the care delivered by PCPCHs. Please see the PCPCH Standards Advisory Committee website[1] for the full Committee report.

A key theme which emerged from both Committees' deliberations was that of flexibility in application and refinement of the model over time. Based on stakeholder feedback, an implementation plan has been developed that does not incorporate all of the standards articulated by the Committees, but rather a subset of standards that may be more feasible for immediate implementation. It is the intention of the OHA to continually assess the model and, based on experience and feedback, gradually modify and/or incorporate additional standards, moving toward the full model envisioned by the Committees.

This document describes:

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[1] http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/PCPCHStandardsAdvisoryCommittee.shtml

- The PCPCH Standards and Measures that will be required for a practice to be recognized as a PCPCH by the OHA as of August 1, 2011;
- Payment methodology objectives for primary care reimbursement that the OHA is seeking to pursue as a payor for approximately 800,000 covered lives; and
- The relationship between National Committee for Quality Assurance (NCQA) Primary Care Medical Home and Oregon PCPCH recognition.

PCPCH Attributes, Standards, and Eligibility

PCPCH Attributes and Standards

The PCPCH Core Attributes and Standards build on the conceptual work of the Oregon Legislature, the Oregon Health Fund Board, the Oregon Health Policy Board and other national and state efforts to describe the PCPCH concept. Each of the six Core Attributes (Figure 1) is associated with multiple Standards that describe the care delivered by PCPCHs. The Core Attributes and Standards (often referred to as "the Standards") are intended to establish a common framework for understanding the structure and functions of a PCPCH from the patient and family perspective. The Standards Advisory Committees felt strongly that incorporating patient-centered language into the Standards' definitions would help clarify the benefits of a PCPCH to patients and the general public (Figure 1).

Figure 1. Core Attributes of Patient Centered Primary Care Homes

PCPCH Eligibility

Any health care practice that is able to meet the PCPCH Standards through the process described in the next section is eligible to be recognized as a PCPCH. This includes but is not limited to physical and behavioral health care providers, solo practitioners, group practices, community mental health centers, rural health clinics, federally qualified health centers, and school-based health centers. A PCPCH does not necessarily need to provide all of the services

described by the Standards on-site, but must be responsible for coordinating and/or offering those services through partnerships within the surrounding community. A robust “health care neighborhood” should be used to support the PCPCH. PCPCHs are encouraged to partner with local public health agencies and community organizations to educate patients, identify community health priorities, and develop plans to improve the overall health of their communities.

PCPCH Measures, Tiers, and Recognition Process

In order for a practice to be recognized as a PCPCH, it must demonstrate the ability to meet the Standards described in the previous section. The Standards Advisory Committees developed a set of detailed PCPCH measures using the Standards framework, and the OHA will use those measures to determine if a practice has met the Standards. This section describes the method used for that determination and the PCPCH recognition process.

PCPCH Measures and Tiers

The PCPCH measures are divided into "Must-Pass" measures and other measures that place the practice on a scale of maturity or 'tier' that reflect basic to more advanced PCPCH functions. Must-Pass and Tier 1 measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advanced functions.

Except for the 10 Must-Pass measures, each measure is assigned a point value corresponding to the Tier. For a practice to be recognized as a PCPCH, it must meet the following point allocation criteria:

- Tier 1: 30 – 60 points and all 10 Must-Pass Measures
- Tier 2: 65 – 125 points and all 10 Must-Pass Measures
- Tier 3: 130 points or more and all 10 Must-Pass Measures

A practice's point score will be calculated through the recognition process described on page 6.

See Appendix A for a detailed list of Measures and corresponding point assignment.

Contractual Attestation

In order to be recognized as a PCPCH, a practice must contractually attest to meeting certain standards as well as submit data elements. The contractual attestation will be contained in an agreement between a practice and the managed care plan, insurance carrier, and/or other payor that the practice has a contractual agreement with and also submitted via the web-based process as discussed in the 'Recognition Process' section below. A PCPCH Attestation Template will be developed and published in a companion guide to this document by the OHA no later than October 1, 2011 in order to create uniformity. It is the intent of the OHA to create a process that will minimize the burden placed on providers and minimize the chance of duplicative information requests.

Contractual attestation measures are marked with a "C" in Appendix A. The OHA will not require any additional documentation that a practice meets the standards at this time; however, those practices seeking PCPCH recognition will be subject to random audit by a centralized process to be developed by the OHA. Contractual attestation measures must be submitted once every three years to maintain PCPCH recognition status.

Data Requirements

Part of the recognition process will include submission of data about the practice or the practice's patient population. The data requested will be aggregated at the practice level, not the individual patient level, and there will not be any transfer of any personal health information. The PCPCH measures requiring quantitative data submission are marked with a "D" in Appendix A. A web-based reporting process will be developed by the OHA through which practices, plans and/or other entities can submit data on behalf of the practice. Several of the reporting requirements are already collected by managed care plans, insurance carriers, or other entities for quality improvement. In order to minimize the burden on the practices, a mechanism for obtaining this data through those sources, where applicable, will be developed. For example, data collected by a Medicaid Managed Care Organization on a practice's breast cancer screening rates could be used as one of the Quality Measures referenced in the Accountability attribute (see Appendix A).

While the contractual attestation measures only need to be submitted every three years, measures requiring quantitative data submission must be submitted on an annual basis. See Appendix B for a complete list of data requirements by measure.

Collection of standardized health care quality data across the state will enable the OHA to recognize high-performing practices in a uniform manner, identify targeted areas for state-level quality improvement, and also allow PCPCHs to engage in practice-level quality improvement. Practice-level data collected by the OHA will be disseminated back to each PCPCH so that the PCPCH can identify trends in patient care and target areas for quality improvement activities.

Patient Experience of Care

Assessing patient experience of care is critical to ensuring that patients and families are receiving the right care, at the right time, in the right place. Patient experience of care survey data will be submitted using the same process and frequency as described in the previous 'Data Requirements' section. The preferred method for capturing this information is to use one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools, including the Health Plans and Systems, Clinician and Group, or Patient-Centered Medical Home Modules. To achieve Tier 2 or Tier 3 credit, a PCPCH must use one of the CAHPS survey tools.

Recognition Process

The OHA will develop a web-based reporting process where practices and/or other entities on behalf of the practice will submit required data. Based on the point system described previously, the Oregon PCPCH Program will score PCPCHs by combining the contractual attestation information with the data requirements received. Practices, managed care plans, and insurance carriers will be notified of a PCPCHs Tier score within 60 days of complete data submission. Practices have 180 days to file a request for review with the Oregon PCPCH Program if the practice disagrees with the calculated Tier score.

Recognition requests can be sent to: PCPCH@state.or.us

Or

Office for Oregon Health Policy and Research
Attn: Patient-Centered Primary Care Home Program
General Services Building
1225 Ferry Street SE, 1st Floor
Salem, OR 97301

The OHA will make details available about the web-based reporting process on the Oregon PCPCH Program website[2] by October 1, 2011.

PCPCHs must renew their recognition every three years. If during this time, a PCPCH believes that it has made progress and should be recognized at a higher tier, it may request its tier status to be reassessed once per calendar year.

NCQA and Oregon PCPCH Recognition

Many practices have already, or are in the process of, pursuing Patient Centered Medical Home (PCMH) recognition by the National Committee for Quality Assurance (NCQA). While this model is not identical to the Oregon PCPCH model, there are areas of commonality. The OHA will recognize PCMH sites at the level that the NCQA has recognized the site, with submission of additional information. Depending on the version of NCQA recognition that was used, practices seeking Oregon PCPCH recognition must contractually attest to being a NCQA recognized PCMH and, submit additional information as follows:

In addition to the 2008 NCQA PCMH Criteria:

- Contractually attest to documenting a screening strategy for mental health, substance use, or developmental conditions and documenting on-site and local referral resources.
- Contractually attest to demonstrating a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.
- Contractually attest to tracking and/or report metrics from the core and/or menu set of PCPCH Quality Measures found in Appendix B, Table 2.

In addition to the 2011 NCQA PCMH Criteria:

- Contractually attest to demonstrating a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

[2] http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/index.shtml

- Contractually attest to tracking and/or report metrics from the core and/or menu set of quality measures found in Appendix B, Table 2.

For a more detailed illustration of the additional requirements for an NCQA recognized practice to achieve Oregon PCPCH recognition, see Appendix C.

Primary Care Payment Reform Objectives

The Oregon Health Policy Board has directed the Oregon Health Authority to pursue innovative payment methods that reward efficiency and improve health outcomes. Such innovations in primary care would reimburse providers for currently non-reimbursable care coordination functions, which could allow providers to take a more person-centered as opposed to visit-based approach to care delivery.

Managed care organizations (MCO) and health insurance carriers who do not currently have innovative payment methodology arrangements in place with their primary care provider networks must provide a specific PCPCH payment on top of the fee-for-service (FFS) schedule to practices meeting PCPCH criteria. This payment must correspond to the PCPCH Tier for which a practice qualifies. For example, the payment rate to Tier 2 practices must be larger than the payment rate to Tier 1 practices. When developing the payment rate, the MCO and/or carrier must consider incurred practice costs for meeting the PCPCH criteria including but not limited to electronic medical record implementation and upgrade, care coordination, and time dedicated to quality improvement.

For those MCOs and/or carriers that choose to use an innovative payment methodology arrangement with their providers, they must describe how this methodology meets the following objectives:

1. Provides financial support for meeting the PCPCH standards;
2. Recognizes PCPCHs for meeting the increasingly robust levels of standards; and
3. Is responsive to the OHA goal of pursuing methodologies that move from a predominately fee-for-service system to payment methods that base reimbursement on the quality rather than the quantity of services provided.

Table 1. Initial Implementation Measures for Patient Centered Primary Care Homes

Core Attribute #1: Access to Care *"Health care team, be there when we need you."*				
Standard	**PCPCH Point Tier**			
	Must-Pass ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **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 and reports results. (D)[3]	**1.A.2** PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools[4] and reports results on the access to care domain. (D)	**1.A.3** PCPCH surveys a sample of its population using one of the CAHPS survey tools, reports results on access to care domain and demonstrates improvement or meets a benchmark with patient satisfaction in access to care. (D)
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. (C)[5]	N/A	N/A
1.C) Telephone & Electronic Access	**1.C.0** PCPCH provides continuous access to clinical advice by telephone. (C)	N/A	N/A	N/A

[3] D = Data report
[4] Acceptable CAHPS survey tools include the Health Plans and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.
[5] C = Contractual attestation

Core Attribute #2: Accountability *"Take responsibility for making sure we receive the best possible health care."*				
Standard	**PCPCH Point Tier**			
	Must-Pass ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
2.A) Performance & Clinical Quality Improvement	**2.A.0** PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures. (C)	N/A	**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. (D)	**2.A.3** PCPCH tracks, reports to the OHA, and demonstrates improvement or meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D)
Core Attribute #3: Comprehensive Whole Person Care *"Provide or help us get the health care, information, and services we need."*				
3.A) Preventive Services	N/A	**3.A.1** PCPCH offers or coordinates 90% of recommended preventive services (Grade A or B USPTF and/or Bright Futures periodicity guideline).[6] (C)	N/A	N/A

[6] The full list of services receiving a United States Preventive Services Task Force (USPSTF) Grade A or B can be found at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The Bright Futures list of recommended services and periodicity can be found at: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.

Standard	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** 5 points each	**Tier 2** 10 points each	**Tier 3** 15 points each
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 transitions of care; Office-based procedures and diagnostic tests; Patient education and self-management. (C)	N/A	N/A	N/A
3.C) Mental Health, Substance Abuse, & Developmental Services	**3.C.0** PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources. (C)	N/A	**3.C.2** PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers. (C)	**3.C.3** PCPCH documents actual or virtual co-location with specialty mental health, substance abuse, or developmental providers. (C)
3.D) Comprehensive Health Assessment & Intervention	N/A	**3.D.1** PCPCH documents comprehensive health assessment and intervention for at least three health risk or developmental promotion behaviors. (C)	N/A	N/A

Core Attribute #4: Continuity **"Be our partner over time in caring for us."**				
Standard	**PCPCH Point Tier**			
	Must-Pass ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
4.A) Personal Clinician Assigned	**4.A.0** PCPCH reports the percentage of active patients assigned a personal clinician and/or team. (D)	N/A	**4.A.2** PCPCH demonstrates improvement on the percentage of active patients assigned to a personal clinician and/or team. (D)	**4.A.3** PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team. (D)
4.B) Personal Clinician Continuity	**4.B.0** PCPCH reports the percent of patient visits with assigned clinician/team. (D)	N/A	**4.B.2** PCPCH demonstrates improvement in the percent of patient visits with assigned clinician/team. (D)	**4.B.2** PCPCH meets a benchmark in the percent of patient visits with assigned clinician/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. (C)	N/A	N/A	N/A

Standard	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** 5 points each	**Tier 2** 10 points each	**Tier 3** 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). (C)
4.E) Specialized Care Setting	**4.E.0** PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (C)	N/A	N/A	N/A
Core Attribute #5: Coordination & Integration *"Help us navigate the health care system to get the care we need in a safe and timely way."*				
5.A) Population Data Management	N/A	**5.A.1a** PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population. [7] (C)	N/A	N/A

[7] This could be achieved through use of a panel management system and/or registry.

Standard	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** 5 points each	**Tier 2** 10 points each	**Tier 3** 15 points each
5.A) Population Data Management *(continued)*	N/A	**5.A.1b** PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.[8] (C)	N/A	N/A
5.B) Electronic Health Record	N/A	N/A	N/A	**5.B.3** PCPCH has an electronic health record and demonstrates "meaningful use" of the electronic record, according to CMS rules. (C)
5.C) Care Coordination	N/A	**5.C.1** PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care. (C)	**5.C.2** PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (C)	N/A

[8] PCHs may choose to create lists or registries of sub-populations based on a variety of conditions (e.g. diabetes or pregnancy) or demographic characteristics (e.g. children < age 1 or women). Proactive management could be demonstrated through the use of a list or registry to track and improve care delivery through strategies such as care protocols and patient or clinician reminders.

Standard	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
5.D) Test & Result Tracking	N/A	**5.D.1** PCPCH demonstrates tracking of 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. (C)	N/A	N/A
5.E) Referral & Specialty Care Coordination	N/A	**5.E.1a** PCPCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. (C) **5.E.1b** PCPCH either manages hospital or skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings. (C)	N/A	**5.E.3** PCPCH tracks referrals and coordinates care where appropriate for community settings outside the PCH (such as dental, educational, social service, foster care, public health, or long term care settings). (C)

Standard	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
5.F) Comprehensive Care Planning	N/A	N/A	**5.F.2** PCPCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan that includes the following: self management goals; goals of preventive and chronic illness care; action plan for exacerbations of chronic illness (when appropriate); end of life care plans (when appropriate). (C)	N/A
5.G) End of Life Planning	**5.G.0** PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (C)	N/A	N/A	N/A

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	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** 5 points each	**Tier 2** 10 points each	**Tier 3** 15 points each
6A) Language / Cultural Interpretation	**6.A.0** PCPCH documents the offer and/or use of either providers who speak a patient and family's language or time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice. (C)	N/A	N/A	N/A
6B) Education & Self-Management Support	N/A	**6.B.1** PCPCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. (C)	N/A	N/A

Standard	PCPCH Point Tier			
	Must-Pass ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
6C) Experience of Care	N/A	**6.C.1** PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family centered care. The recommended patient experience of care survey is one of the CAHPS survey tools. (D)	**6.C.2** PCPCH surveys a sample of its population using one of the CAHPS survey tools and reports results on the access to care domain. (D)	**6.C.3** PCPCH surveys a sample of its population using one of the CAHPS survey tools and demonstrates improvement or meets benchmarks on the majority of the domains. (D)

Data Requirements

The data requested will be aggregated at the practice level, not the individual patient level, and there will not be any transfer of any personal health information. A web-based reporting process will be developed by the OHA where practices, plans and/or other entities can submit data on behalf of the practice.

Measure specification, thresholds for demonstrating improvement, and benchmarks for all of the following measures will be developed and published in a companion guide by October 1, 2011.

Access Measure 1

Tier 1: PCPCH surveys a sample of its population on satisfaction with in-person access to care.

Tier 2: PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools[9] and reports results on the access to care domain.

Tier 3: PCPCH surveys a sample of its population using one of the CAHPS survey tools, reports results on the access to care domain and demonstrates improvement or meets a benchmark with patient satisfaction in access to care.

Continuity Measure 1

Tier 1: PCPCH reports the percentage of active patients assigned a personal clinician and/or team.

Tier 2: PCPCH demonstrates improvement on the percentage of active patients assigned to a personal clinician and/or team.

Tier 3: PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team.

Continuity Measure 2

Tier 1: PCPCH reports the percent of patient visits with assigned clinician/team.

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[9] Acceptable CAHPS survey tools include the Health Plans and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.

Tier 2: PCPCH demonstrates improvement in the percent of patient visits with assigned clinician/team.

Tier 3: PCPCH meets a benchmark in the percent of patient visits with assigned clinician/team.

Family-Centered Measure 4

Tier 1: PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family centered care. The recommended patient experience of care survey is one of the CAHPS survey tools.

Tier 2: PCPCH surveys a sample of its population using one of the CAHPS survey tools and reports results.

Tier 3: PCPCH surveys a sample of its population using one of the CAHPS survey tools and demonstrates improvement or meets benchmarks on the majority of the domains.

Accountability 1

Tier 2: PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures (see Table 2).

Tier 3: PCPCH tracks, reports to the OHA, and demonstrates improvement or meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures.

Family practitioners are encouraged to report on measures that are reflective of their patient population (i.e. two adult measures and one pediatric measure or vice versa)

NOTE: An exception process will be developed for those practices who are currently tracking measures for quality improvement purposes that are not a part of the core and menu set. Practices will be allowed to substitute up to two measures from the core and/or menu set. This will allow flexibility for those practices that are already undertaking QI efforts while also ensuring that there is some degree of consistency in reporting across primary care home providers. Details on the exception process will be developed and published in a companion guide to this document also containing measure specifications by October 1, 2011.

Table 2. PCPCH Quality Measures

Measure Title	Adult Core Set	Pediatric Core Set	Menu Set	National Quality Forum[10] Number
Adult Weight Screening and Follow-up	X			NQF0421
Medical Assistance With Smoking and Tobacco Use Cessation	X			NQF0028
Breast cancer screening	X			NQF0031
Cervical cancer screening	X			NQF0032
Colorectal cancer screening	X			NQF0034
Hemoglobin A1c testing	X			NQF0057
Body Mass Index (BMI) Percentile		X		NQF0024
Asthma Assessment		X		NQF0001
Developmental screening < 3 years old		X		N/A
Well child care (0 – 15 months)		X		N/A (CHIPRA Core Set Measure #10)
Well child care (3 – 6 years)		X		N/A (CHIPRA Core Set Measure #11)
Adolescent well-care (12-21 years)		X		N/A (CHIPRA Core Set Measure #12)

[10] The National Quality Forum (NQF) is a nonprofit organization that operates to improve the quality of American healthcare. Consensus standards endorsed by NQF are used for measuring and publicly reporting on the performance of different aspects of the healthcare system, and are widely viewed as the "gold standard" for the measurement of healthcare quality.

Measure Title	Adult Core Set	Pediatric Core Set	Menu Set	National Quality Forum Number
Screening for clinical depression and follow-up plan			X	NQF0418
Frequency of ongoing prenatal care			X	N/A (CHIPRA Core Set Measure #2)
Appropriate testing for children with pharyngitis			X	NQF0002
Pneumococcal immunization (65+)			X	NQF0043, NQF0044
Influenza immunization (50+)			X	NQF0039, NQF0041
Coronary Artery Disease (CAD) Composite			X	NQFs 0066, 67, 70, 74
Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse			X	N/A (RAND)
Controlling High Blood Pressure			X	NQF0018
Blood pressure control for patients 18-75 years with diabetes			X	NQF0061
LDL-C control for patients 18-75 years with diabetes			X	NQF0064
Comprehensive Diabetes Care: HbA1c control			X	NQF0575
Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)			X	NQF0108
Use of Appropriate Medications for People with Asthma			X	NQF0036

Measure Title	Adult Core Set	Pediatric Core Set	Menu Set	National Quality Forum Number
Adolescent immunizations up to date at 13 years old			X	N/A (CHIPRA Core Set Measure #6)
Childhood Immunization Status			X	NQF0038
Blood Pressure Measurement			X	NQF0013
Diabetes: Lipid profile			X	NQF0063

Table 3. Oregon PCPCH Program 2008 NCQA Recognition Requirements

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2008 Level 1 NCQA PCMH Recognition	Contractually attests to recognition	N/A	N/A
2008 Level 2 NCQA Recognition	N/A	Contractually attests to recognition	N/A
2008 Level 3 NCQA Recognition	N/A	N/A	Contractually attests to recognition
OR Accountability Measure 1	Contractually attests to tracking one measure from the core and/or menu set of measures in Appendix B	Reports two measures from the core set and one from the menu set of measures in Appendix B	Reports and demonstrates improvement or meets benchmarks on two measures from the core set and one from the menu set of measures in Appendix B
OR Comprehensive Measure 3.1	Contractually attests to meeting measure	Contractually attests to meeting measure	Contractually attests to meeting measure
OR Coordination Measure 7.1	Contractually attests to meeting measure	Contractually attests to meeting measure	Contractually attests to meeting measure

Table 4. Oregon PCPCH Program 2011 NCQA Recognition Requirements

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2011 Level 1 NCQA PCMH Recognition	Contractually attests to recognition	N/A	N/A
2011 Level 2 NCQA Recognition	N/A	Contractually attests to recognition	N/A
2011 Level 3 NCQA Recognition	N/A	N/A	Contractually attests to recognition
OR Accountability Measure 1	Contractually attests to tracking one measure from the core and/or menu set of measures in Appendix B	Reports two measures from the core set and one from the menu set of measures in Appendix B	Reports and demonstrates improvement or meets benchmarks on two measures from the core set and one from the menu set of measures in Appendix B
OR Coordination Measure 7.1	Contractually attests to meeting measure	Contractually attests to meeting measure	Contractually attests to meeting measure