

PATIENT-CENTERED PRIMARY CARE HOME (PCPCH) PRACTICE SELF-ASSESSMENT TOOL

Introduction

Thank you for your interest in the Oregon Patient-Centered Primary Care Home (PCPCH) Program. This Self-Assessment Tool should be used before filling out the web-based PCPCH Recognition Process Application. It has been designed to be used in tandem with the PCPCH Implementation Guide and the PCPCH Technical Assistance and Reporting Guidelines, which are available on the main PCPCH Program web page: www.primarycarehome.oregon.gov.

We recommend that practices use this Self-Assessment Tool to work with staff to accurately answer all questions and gather the required data in advance of filling out the PCPCH Recognition Process Application. This Self-Assessment Tool will also help practices estimate the PCPCH tier the practice can achieve.

PCPCH Self-Assessment Tool Components

- Applicant Organization Information, page 2
- Practice Site Information, page 3
- PCPCH Standards Survey, page 4
- Tally Sheet, page 14
- Self-Assessment for NCQA-recognized PCMHs, page 15

Please carefully read the instructions for each component. Questions can be e-mailed to PCPCH@state.or.us.

Multiple Practice Sites

A practice site is defined by distinct physical location. If your organization operates multiple practice sites that are applying for PCPCH Recognition, at this time a separate PCPCH Recognition Process Application must be filled out for each practice site, although many of the answers may be the same. If all practice sites applying for recognition operate under the same policies and procedures and share the same electronic health record to document patient care, then some questions will be answered the same for each practice site. Other questions require information to be entered for the specific practice site, as indicated.

NCQA-Recognized PCMH Practices

If your practice site is already an NCQA-recognized Patient-Centered Medical Home (PCMH), please skip to the Self-Assessment for NCQA-recognized PCMHs (page 15) for more information and self-assessment instructions.

Applicant Organization Information

In this section of the web-based PCPCH Recognition Application you will be asked to provide information about your organization. The applicant organization may have one or more practice sites. The applicant organization and practice site can be the same entity. You will be asked for practice site information on the next section.

Please note: The organization contact person listed should be the individual completing this application.

Organization Name	
Organization Tax ID	
Organization NPI Number	
Organization OR Medicaid ID	
Organization Contact Person	
Organization Contact Email	
Organization Contact Phone	
Organization Address Line 1	
Organization Address Line 2	
Organization City	
Organization State	
Organization Zip	

Practice Site Information

If your practice site information is different than your organization information, you will be asked to enter your practice site information in this section of the web-based PCPCH application. If you have more than one practice site location, you will complete a separate application for each practice site.

Please note: Practice site is defined by distinct physical location.

Practice Site Name	
Practice Site Tax ID	
Practice Site NPI Number	
Practice Site Oregon Medicaid ID Number	
Practice Site Contact Person	
Practice Site Contact Email	
Practice Site Contact Phone	
Practice Site Address Line	
Practice Site Address Line 1	
Practice Site Address Line 2	
Practice Site City	
Practice Site State	
Practice Site Zip	

PCPCH Standards Survey

The PCPCH Recognition Process application requires the practice to respond to a total of 23 Standards across 6 Core Attributes. The questions in this survey match the standards in the PCPCH Recognition Process application.

- For each standard, the practice should choose the corresponding measure that most accurately represents the practice's operations, policies, and procedures. A representative of the practice is required to attest to the answers and electronically sign this application. Each practice submitting an application is subject to an on-site verification. If a practice knowingly submits false information, this may be considered Medicaid fraud.
- Unless otherwise specified, please select only one answer for each question.
- Each answer has a corresponding point value.
- 10 of the PCPCH standards are labeled as Must-Pass. Practices are required meet all 10 Must-Pass standards in order to achieve PCPCH Recognition. These standards are highlighted in this Self-Assessment Tool. If a Must-Pass standard has multiple choices, the practice must choose, at minimum, the first option.
- Some questions require quantitative data to be collected and recorded. These standards are highlighted in this Self-Assessment Tool and space has been provided to record the required data. Please refer to the [Technical Assistance and Reporting Guidelines](#)¹ for more information about how the numerators and denominators should be calculated.
- You may use the Tally Sheet on page 14 to record the points for your selected answers and estimate the tier level at which OHA will recognize the practice. The Tally Sheet also helps you track if your practice meets the 10 Must-Pass standards and has collected all of the required data.

CORE ATTRIBUTE #1: ACCESS TO CARE

1.A) In-Person Access

1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	5 points
1.A.2 PCPCH surveys a sample of its population on access to care using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools. (Acceptable CAHPS survey tools include the Health Plans and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.)	10 points
1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools and meets a benchmark with patient satisfaction in access to care.	15 points
Practice doesn't meet this PCPCH standard.	0 points

¹ Available at www.primarycarehome.oregon.gov.

1.B) After Hours Access

1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	5 points
Practice doesn't meet this PCPCH standard.	0 points

1.C Telephone & Electronic Access

This is a must-pass standard—it is required.

Practice must meet 1.C.0 in order to receive PCPCH recognition.

1.C.0 PCPCH provides continuous access to clinical advice by telephone.	0 points
Practice doesn't meet this PCPCH standard.	0 points

CORE ATTRIBUTE #2: ACCOUNTABILITY

2.A) Performance & Clinical Quality Improvement

This is a must-pass standard—it is required.

Practice must meet 2.A.0, 2.A.2, or 2.A.3 in order to receive PCPCH recognition.

2.A.0 PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures.	0 points
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.	10 points
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.	15 points
Practice doesn't meet this PCPCH standard.	0 points

Data submission is required if you meet 2.A.2 or 2.A.3.

The practice must choose two measures from either the Adult Core Set or the Pediatric Core Set and one measure from the Menu Set. For each measure chosen, enter the practice site's corresponding data for that measure. Please refer to the [Technical Assistance and Reporting Guidelines](#)² for more information about these quality measures, how the numerator and denominator should be calculated, and measure benchmarks (where available).

NOTE: OHA will allow for exceptions if your practice is currently tracking measures for quality improvement purposes that are not a part of the core and menu set. Practices are allowed to substitute up to two measures from the core and/or menu set by choosing "Other" and specifying the measure and corresponding numerator and denominator. This is to allow

² Available at www.primarycarehome.oregon.gov.

flexibility for those practices that are already undertaking quality improvement (QI) efforts while also ensuring that there is some degree of consistency in reporting across primary care home providers.

Choose two measures from this chart and record corresponding data:

✓	Measure Number	Measure	Numerator	Denominator
Adult Core Set				
	NQF0421	Adult Weight Screening and Follow-up		
	NQF0028	Medical Assistance With Smoking and Tobacco Use Cessation		
	NQF0028	Breast cancer screening		
	NQF0032	Cervical cancer screening		
	NQF0034	Colorectal cancer screening		
	NQF0057	Hemoglobin A1c testing		
Pediatric Core Set				
	NQF0024	Body Mass Index (BMI) Percentile		
	NQF0001	Asthma Assessment		
	N/A	Developmental screening < 3 years old		
	CHIPRA Core Set Measure #10	Well child care (0 – 15 months)		
	CHIPRA Core Set Measure #11	Well child care (3 – 6 years)		
	CHIPRA Core Set Measure #12	Adolescent well-care (12-21 years)		
Other Measures				
Please specify measure number, name, and corresponding numerator and denominator.				

Choose one measure from this chart and record corresponding data:

✓	Measure Number	Measure	Numerator	Denominator
Menu Set				
	NQF0421	Adult Weight Screening and Follow-up		
	NQF0028	Medical Assistance With Smoking and Tobacco Use Cessation		
	NQF0031	Breast cancer screening		
	NQF0032	Cervical cancer screening		
	NQF0034	Colorectal cancer screening		
	NQF0057	Hemoglobin A1c testing		
	NQF0024	Body Mass Index (BMI) Percentile		
	NQF0001	Asthma Assessment		

✓	Measure Number	Measure	Numerator	Denominator
Menu Set continued				
	NQF1448	Developmental screening < 3 years old		
	CHIPRA Core Set Measure #10	Well child care (0 – 15 months)		
	CHIPRA Core Set Measure #11	Well child care (3 – 6 years)		
	CHIPRA Core Set Measure #12	Adolescent well-care (12-21 years)		
	NQF0418	Screening for clinical depression and follow-up plan		
	CHIPRA Core Set Measure #2	Frequency of ongoing prenatal care		
	NQF0002	Appropriate testing for children with pharyngitis		
	NQF0043, NQF0044	Pneumococcal immunization (65+)		
	NQF0039, NQF0041	Influenza immunization (50+)		
	NQFs 0066, 67, 70, 74	Coronary Artery Disease (CAD) Composite		
	RAND	Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse		
	NQF0018	Controlling High Blood Pressure		
	NQF0061	Blood pressure control for patients 18-75 years with diabetes		
	NQF0064	LDL-C control for patients 18-75 years with diabetes		
	NQF0575	Comprehensive Diabetes Care: HbA1c control		
	NQF0108	Follow-up care for children prescribed ADHD medication		
	NQF0108	Use of Appropriate Medications for People with Asthma		
	CHIPRA Core Set Measure #6	Adolescent immunizations up to date at 13 years old		
	NQF0038	Childhood Immunization Status		
	NQF0013	Blood Pressure Measurement		
	NQF0063	Diabetes: Lipid profile		
Other Measures				
Please specify measure number, name, and corresponding numerator and denominator.				

CORE ATTRIBUTE #3: COMPREHENSIVE WHOLE PERSON CARE

3.A) Preventive Services

3.A.1 PCPCH offers or coordinates 90% of recommended preventive services (Grade A or B USPTF and/or Bright Futures periodicity guideline).	5 points
Practice doesn't meet this PCPCH standard.	0 points

3.B) Medical Services

This is a must-pass standard—it is required.

Practice must meet 3.B.0 in order to receive PCPCH recognition.

3.B.0 PCPCH 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.	0 points
Practice doesn't meet this PCPCH standard.	0 points

3.C) Mental Health, Substance Abuse, & Developmental Services

This is a must-pass standard—it is required.

Practice must meet 3.A.0, 3.A.2, or 3.A.3 in order to receive PCPCH recognition.

3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.	0 points
3.C.2 PCPCH directly collaborates or co-manages patients with specialty mental health, substance abuse, or developmental providers.	10 points
3.C.3 PCPCH is co-located, either actually or virtually, with specialty mental health, substance abuse, or developmental providers.	15 points
Practice doesn't meet this PCPCH standard.	0 points

3.D) Comprehensive Health Assessment

3.D.1 PCPCH has the ability to conduct comprehensive health assessments and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	5 points
Practice doesn't meet this PCPCH standard.	0 points

CORE ATTRIBUTE #4: CONTINUITY

4.A) Personal Clinician Assigned

This is a must-pass standard—it is required.

Practice must meet 4.A.0 or 4.A.3 in order to receive PCPCH recognition.

4.A.0 PCPCH reports the percentage of active patients assigned a personal clinician and/or team.	0 points
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team.	15 points
Practice doesn't meet this PCPCH standard.	0 points

Data submission is required for this standard.

Enter the numerator and denominator that correspond to the measure chosen. For measure specifications, please refer to the Technical Assistance and Reporting Guidelines.

Numerator	Denominator

4.B) Personal Clinician Continuity

This is a must-pass standard—it is required.

Practice must meet 4.B.0 or 4.B.3 in order to receive PCPCH recognition.

4.B.0 PCPCH reports the percent of patient visits with assigned clinician/team.	0 points
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician/team.	15 points
Practice doesn't meet this PCPCH standard.	0 points

Data submission is required for this standard.

Enter the numerator and denominator that correspond to the measure chosen. For measure specifications, please refer to the Technical Assistance and Reporting Guidelines.

Numerator	Denominator

4.C) Organization of Clinical Information

This is a must-pass standard—it is required.

Practice must meet 4.C.0 in order to receive PCPCH recognition.

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.	0 points
Practice doesn't meet this PCPCH standard.	0 points

4.D) Clinical Information Exchange

4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	15 points
Practice doesn't meet this PCPCH standard.	0 points

4.E) Specialized Care Setting

This is a must-pass standard—it is required.

Practice must meet 4.E.0 in order to receive PCPCH recognition.

4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	0 points
Practice doesn't meet this PCPCH standard.	0 points

CORE ATTRIBUTE #5: COORDINATION & INTEGRATION

5.A) Population Data Management

**For this standard, the practice can select ALL measures that the practice meets.*

5.A.1a PCPCH has the ability to identify, aggregate, and display up-to-date data regarding its patient population.	5 points
5.A.1b PCPCH has the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.	5 points
Practice doesn't meet this PCPCH standard.	0 points

5.B) Electronic Health Record

5.B.3 PCPCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules.	15 points
Practice doesn’t meet this PCPCH standard.	0 points

5.C) Care Coordination

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.	5 points
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	10 points
Practice doesn’t meet this PCPCH standard.	0 points

5.D) Test & Result Tracking

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.	5 points
Practice doesn’t meet this PCPCH standard.	0 points

5.E) Referral & Specialty Care Coordination

**For this standard, the practice can select ALL measures that the practice meets.*

5.E.1a PCPCH tracks referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	5 points
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.	5 points
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).	15 points
Practice doesn’t meet this PCPCH standard.	0 points

5.F) Comprehensive Care Planning

5.F.2 PCPCH has 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 provides 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).	10 points
Practice doesn't meet this PCPCH standard.	0 points

5.G) End of Life Planning

This is a must-pass standard—it is required.

Practice must meet 5.G.0 in order to receive PCPCH recognition.

5.G.0 PCPCH offers or coordinates hospice and palliative care and counseling for patients and families who may benefit from these services.	0 points
Practice doesn't meet this PCPCH standard.	0 points

CORW ATTRIBUTE #6: PERSON- AND FAMILY-CENTERED CARE

6.A) Language / Cultural Interpretation

This is a must-pass standard—it is required.

Practice must meet 6.A.0 in order to receive PCPCH recognition.

6.A.0 PCPCH offers and/or uses 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.	0 points
Practice doesn't meet this PCPCH standard.	0 points

6.B) Education & Self-Management Support

6.B.1 PCPCH provides patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.	5 points
Practice doesn't meet this PCPCH standard.	0 points

6.C) Experience of Care

6.C.1 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must at least include questions on access to care, provider communication, coordination of care, and practice staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.	5 points
6.C.2 PCPCH surveys a sample of its population using one of the CAHPS survey tools.	10 points
6.C.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools and meets benchmarks on a majority of the survey domains.	15 points
Practice doesn't meet this PCPCH standard.	0 points

For domain benchmarks, please refer to the Technical Assistance and Reporting Guidelines.

Tally Page

Enter the score that corresponds with the answer selected for each standard. Practices are required to meet all 10 must-pass standard and collect data required for select standards.

Standard	Meet Must-Pass ✓	Enter Score	Quantitative Data Required ✓
1.A) In-Person Access			
1.B) After Hours Access			
1.C) Telephone & Electronic Access			
2.A) Performance & Clinical Quality Improvement			
3.A) Preventive Services			
3.B) Medical Services			
3.C) Mental Health, Substance Abuse, & Developmental Services			
3.D) Comprehensive Health Assessment & Intervention			
4.A) Personal Clinician Assigned			
4.B) Personal Clinician Continuity			
4.C) Organization of Clinical Information			
4.D) Clinical Information Exchange			
4.E) Specialized Care Setting			
5.A) Population Data Management			
5.B) Electronic Health Record			
5.C) Care Coordination			
5.D) Test & Result Tracking			
5.E) Referral & Specialty Care Coordination			
5.F) Comprehensive Care Planning			
5.G) End of Life Planning			
6.A) Language/Cultural Interpretation			
6.B) Education & Self-Management Support			
6.C) Experience of Care			
TOTAL			

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

Self-Assessment for NCQA-Recognized PCMH Practices

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 some additional information in the web-based PCPCH Recognition Process application.

NCQA-recognized practices also have the option of submitting a full PCPCH application, with the possibility of achieving a higher PCPCH tier level. If your practice wishes to submit a full PCPCH application, follow the instructions from the beginning of this Self-Assessment Tool.

If your practice site is already an NCQA-recognized Patient-Centered Medical Home (PCMH) and wishes to use its NCQA level for PCPCH recognition, use the following components of this Self-Assessment Tool to prepare for completing the web-based PCPCH Recognition Process application:

- Applicant Organization Information (page 3);
- Practice Site Information (page 4);
- On the next page (page 16), choose the version of the NCQA standards used to recognize the practice (2008 or 2011) and follow instructions on the questions in the PCPCH Standards Survey your practice is required to answer; and
- Use the charts that follow to estimate your PCPCH tier level.

2008 NCQA PCMH Recognition

Please answer the following questions in the PCPCH Standards Survey:

- 2A. Performance & Clinical Quality Improvement on page 5
- 3C. Mental Health, Substance Abuse, & Developmental Services on page 8
- 5G. End of Life Planning on page 12

Additional required PCPCH standards	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
	2008 Level 1 NCQA PCMH Recognition	2008 Level 2 NCQA Recognition	2008 Level 3 NCQA Recognition
2A. Performance & Clinical Quality Improvement	Meets 2.A.0	Meets and submits data for 2.A.2	Meets and submits data for 2.A.3
3C. Mental Health, Substance Abuse, & Developmental Services	Meets 3.C.0, 3.C.2, or 3.C.3	3.C.0, 3.C.2, or 3.C.3	3.C.0, 3.C.2, or 3.C.3
5G. End of Life Planning	Meets 5.G.0	Meets 5.G.0	Meets 5.G.0

2011 Level 1 NCQA PCMH Recognition

Please answer the following questions in the PCPCH Standards Survey:

- 2A. Performance & Clinical Quality Improvement on page 5
- 5G. End of Life Planning on page 12

Additional required PCPCH standards	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
	2011 Level 1 NCQA PCMH Recognition	2011 Level 2 NCQA Recognition	2011 Level 3 NCQA Recognition
2A. Performance & Clinical Quality Improvement	Meets 2.A.0	Meets and submits data for 2.A.2	Meets and submits data for 2.A.3
5G. End of Life Planning	Meets 5.G.0	Meets 5.G.0	Meets 5.G.0