

CHAPTER 409
OREGON HEALTH AUTHORITY,
OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

DIVISION 55
PATIENT-CENTERED PRIMARY CARE HOME PROGRAM

409-055-0000

Purpose and Scope

These rules (OAR 409-055-0000 to 409-055-0090) establish the Patient-Centered Primary Care Home (PCPCH) Program and define criteria and process that the Authority shall use to recognize and verify status as PCPCHs. The 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.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0010

Definitions

The following definitions apply to OAR 409-055-0000 to 409-055-0090:

- (1) “Administrator” means the administrator or designee of The Office for Oregon Health Policy and Research as defined in ORS 442.011.
- (2) “Authority” means the Oregon Health Authority.
- (3) “CHIPRA Core Measure Set” means the initial core set of children's health care quality measures released by the Centers for Medicare and Medicaid Services in 2009 for voluntary use by Medicaid and CHIP programs.
- (4) “NCQA” means National Committee for Quality Assurance.
- (5) “Office” means the Office for Oregon Health Policy and Research.
- (6) “Patient Centered Medical Home (PCMH)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.

- (7) “Patient-Centered Primary Care Home (PCPCH)” means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.
- (8) “Personal Health Information” means demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care.
- (9) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.
- (10) “Program” means Patient-Centered Primary Care Home Program.
- (11) “Program website” means www.primarycarehome.oregon.gov.
- (12) “Provider” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.
- (13) “Recognition” means the process through which the Authority determines if a practice has met the Oregon Patient-Centered Primary Care Home Standards.
- (14) “Recognized” means that the Authority has affirmed that a practice meets the Oregon Patient-Centered Primary Care Home Standards.
- (15) “Tier” means the level of Patient-Centered Primary Care Home at which the Authority has scored a practice.
- (16) “Verification” means the process that Office for Oregon Health Policy and Research shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of Patient-Centered Primary Care Home recognition.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0020

Program Administration

- (1) The Program is intended to ensure that there is a uniform process for recognizing PCPCHs throughout the State of Oregon in order to support primary care transformation.

- (2) The Authority shall recognize practices as PCPCHs upon meeting defined criteria through the Program.
- (3) The Authority shall administer the Program, including data collection and analysis, recognition, and verification that a practice meets the defined PCPCH criteria. The Authority may also provide technical assistance as is feasible.
- (4) The Authority may contract for any of the work it deems necessary for efficient and effective administration of the Program.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0030

Practice Application and Recognition Process

- (1) Practices or other entities on behalf of the practice shall submit a PCPCH Recognition Process Application electronically to the Authority via the Program's online application system found on the Program website. The application shall include data per OAR 409-055-0040.
- (2) The Authority shall review the application for completed data and compliance with the criteria in OAR 409-055-0040.
- (3) When the PCPCH applicant meets the criteria requirements, the Authority shall deem the applicant as a Recognized PCPCH Practice and assign a Tier level.
- (4) The Authority shall keep instructions and criteria for submitting a PCPCH Recognition Process Application posted on the Program website.
- (5) Practices shall be notified in writing or electronically of a PCPCHs Tier score or contacted for additional information within 60 days of application submission.
- (6) A practice may be denied PCPCH recognition if it does not meet the criteria in OAR 409-055-0040.
- (7) Practices must file a request for review with the Program within 90 days if the practice disagrees with the calculated Tier score.
- (8) PCPCHs must renew their recognition annually or at the discretion of the OHA, but no less than 12 months from the effective recognition date identified to the practice by the Authority. If during the year, a PCPCH believes that it meets the criteria to be recognized at a higher tier, it may request to have its tier status reassessed by re-submitting an application not more than once every six months.

- (9) The effective recognition date identified by the Authority shall be the date on which the Authority has completed the application review process.
- (10) The Authority reserves the right to identify a recognition date other than the date of application review process completion.
- (11) It is the intent of the Program to refine the criteria per OAR 409-055-0040 during the first two years of implementation of the Program based on PCPCH provider and stakeholder feedback. After this time, the Authority intends to move to a recognition renewal process of once every three years.
- (12) Recognition requests may be sent electronically or by mail to the address posted on the Program website.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0040

Recognition Criteria

- (1) 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.
- (2) 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.
- (3) Tier 2 and Tier 3 measures reflect intermediate and advanced functions.
- (4) 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:
 - (a) Tier 1: 30 – 60 points and all 10 Must-Pass Measures
 - (b) Tier 2: 65 – 125 points and all 10 Must-Pass Measures
 - (c) Tier 3: 130 points or more and all 10 Must-Pass Measures
- (5) A practice’s point score shall be calculated through the recognition process pursuant to OAR 409-055-0030.
- (6) See Table 1 for a detailed list of Measures and corresponding point assignment.

- (7) See Tables 2.A and 2.B for a detailed list of the PCPCH Quality Measures referred to in Table 1, 2.A) Performance & Clinical Quality Improvement, 4.A) Personal Clinician Assigned, and 4.D) Personal Clinician Continuity.
- (8) Data specifications for the measures listed in Table 2 shall be available on the Program website.
- (9) Quantitative data shall be aggregated at the practice level, not the individual patient level, and there may not be any transfer of any personal health information from the practice to the Authority during the PCPCH application process.
- (10) Measure specification, thresholds for demonstrating improvement, and benchmarks for quantitative data elements shall be developed by the Authority and made available on the Program website.
- (11) NCQA recognition will be acknowledged in the Authority's PCPCH recognition process; however, a practice is not required to use its NCQA recognition to meet the Oregon PCPCH standards. A practice that does not wish to use its NCQA recognition to meet the Oregon PCPCH standards must indicate so during the PCPCH application process and submit a complete PCPCH application.
- (12) Depending on the version of NCQA recognition that was used, practices seeking Oregon PCPCH recognition and wish to use their NCQA PCMH status shall attest to being a NCQA recognized PCMH and submit additional information.
- (13) Additional required elements for NCQA PCMH recognized practices choosing to use their NCQA status are listed in Table 3 for PCMH practices using 2008 NCQA criteria and Table 4 for PCMH practices using 2011 NCQA criteria.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0050

Data Reporting Requirements for Recognized PCPCHs

- (1) In order to be recognized as a PCPCH, a practice must attest to meeting the standards described in Table 1 as well as submit quantitative data elements as described in Tables 1 and 2.
- (2) The attestation shall be submitted electronically via the web-based process pursuant to OAR 409-055-0030.
- (3) Recognized PCPCHs shall be scored and assigned a Tier level pursuant to OAR 409-055-0040.

- (4) Attestation data must be submitted by PCPCHs annually as a part of the recognition renewal process.
- (5) Part of the recognition process shall also include submission of quantitative data about the practice or the practice's patient population.
- (6) Quantitative data shall be submitted electronically via the web-based reporting process.
- (7) Quantitative data elements selected from Table 2 must be submitted by recognized PCPCHs annually for those practices submitting data to meet standard 2.A.2 or 2.A.3.
- (8) If approved by the practice and the Authority, other entities may submit information on behalf of a practice.
- (9) Specific data elements required for PCPCH recognition shall be posted on the PCPCH Program website.
- (10) The Authority shall have discretion to make exceptions to the reporting requirements above for practices collecting data elements outside of those on Table 2 for the purpose of quality improvement activities.
- (11) The Authority shall have discretion to make exceptions to any of the reporting requirements referred to in OAR 409-055.
- (12) Practices may request an exception to the reporting requirements on the PCPCH application form.
- (13) The Authority will notify the practice within 60 days of complete application submission whether or not the requested exception has been granted.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0060

Verification

- (1) The Authority shall conduct at least one verification review of each recognized PCPCH to determine compliance with PCPCH criteria every five years and at such other times as the Authority deems necessary or at the request of the Division of Medical Assistance Programs (DMAP) or any other applicable program within the Authority. The purpose of the review is to verify reported attestation and quantitative data elements for the purposes of confirming recognition and Tier level.
- (2) PCPCHs selected for verification shall be notified no less than 30 days prior to the scheduled review.

- (3) PCPCHs shall permit Authority staff access to the practice's place of business during the review.
- (4) A verification review may include but is not limited to:
 - (a) Review of documents and records.
 - (b) Review of patient medical records.
 - (c) Review of electronic medical record systems, electronic health record systems, and practice management systems.
 - (d) Review of data reports from electronic systems or other patient registry and tracking systems.
 - (e) Interviews with practice management, clinical and administrative staff.
 - (f) On-site observation of practice staff.
 - (g) On-site observation of patient environment and physical environment.
- (5) Following a review, Authority staff may conduct an exit conference with the PCPCH representative(s). During the exit conference Authority staff shall:
 - (a) Inform the PCPCH representative of the preliminary findings of the review; and
 - (b) Give the PCPCH a reasonable opportunity to submit additional facts or other information to the Authority staff in response to those findings.
- (6) Following the review, Authority staff shall prepare and provide the PCPCH specific and timely written notice of the findings.
- (7) If the findings result in a referral to the Division of Medical Assistance Programs per OAR 409-055-0070, Authority staff shall submit the applicable information to the Division of Medical Assistance Programs for its review and determination of appropriate action.
- (8) If no deficiencies are found during a review, the Authority shall issue written findings to the PCPCH indicating that fact.
- (9) If the reviewer's written notice of findings indicates that the PCPCH was in compliance with PCPCH standards and criteria and no deficiencies were cited, the PCPCH representative shall sign and date the written notice and return it to the Authority.
- (10) If deficiencies are found, the Authority shall take informal or formal enforcement action in compliance with OAR 409-055-0070.

- (11) The Authority may share application information and content submitted by practices and/or verification findings only with managed care plans and/or insurance carriers with which the Authority contracts.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0070

Compliance

- (1) If the Authority finds that the practice is not in compliance with processes as attested to, the Authority shall:
 - (a) Require a waiver with timeline to correct deficiency
 - (b) Issue a written warning with timeline to correct deficiency
- (2) For steps (1)(a) and (1)(b), the Authority will review outcomes in accordance with the waiver or warning, and if remedied, no further action will be taken.
- (3) If a practice fails to move into compliance within 90 days of identification of non-compliance with attested information, the Authority may issue a letter of non-compliance and amend the practice's PCPCH recognition to reflect the appropriate Tier level or revoke its PCPCH status.
- (4) If non-compliance is identified, the Authority will make this information available to managed care plans and insurance carriers with which the Authority contracts.
- (5) A practice that has had its PCPCH status revoked may be reissued after the Authority determines that compliance with PCPCH Standards has been achieved satisfactorily.
- (6) In order for the Authority to receive federal funding for Medicaid clients receiving services through a PCPCH, documentation of certain processes are required by the Centers for Medicare and Medicaid Services. Documentation requirements can be found in OAR 410-141-0860. If non-compliance is due to lack of documentation required per OAR 410-141-0860, a referral may be made to the Division of Medical Assistance Programs' provider audit unit.
- (7) If the Authority finds a lack of documentation per OAR 410-141-0860 to support the authorized tier level, the Authority may conduct an audit pursuant to the standards in OAR 943-120-1505

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0080**Insurance Carrier, Managed Care Plan, and Public Stakeholder Communication**

- (1) The Authority shall develop a system for making recognized PCPCH Tier status recognition information available to insurance carriers and managed care organizations.
- (2) The Authority shall maintain and update monthly the recognized PCPCH Tier status lists.
- (3) The Authority shall develop a system for making recognized PCPCH practice names available to the general public through the Program website.
- (4) Practices who do not wish to have their name listed on the publicly available list should send an e-mail to PCPCH@state.or.us with the title “opt-out” in the subject line within 10 business days of receiving confirmation of Tier status per OAR 409-055-0040.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0090**Reimbursement Objectives**

- (1) One objective of these standards is to facilitate appropriate reimbursement for PCPCHs consistent with their recognized Tier levels. The standards and Tier recognition process established in this rule are consistent with statutory objectives to align financial incentives to support utilization of PCPCHs, in recognition of the standards that are required to be met at different Tiers.
- (2) Managed care plans and insurance carriers may obtain from the Authority the Tier level recognition of any practice.
- (3) Within applicable programs, the Authority shall develop and implement reimbursement methodologies that reimburse practices based on recognition of Tier level, taking into consideration incurred practice costs for meeting the Tier criteria.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

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

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

Core Attribute #1: Access to Care <i>“Health care team, be there when we need you.”</i>				
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. (C) ¹	1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools. ² (C)	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. (C)
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) ³	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

¹ (D) = Quantitative data report

² Acceptable CAHPS survey tools include the Health Plans and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.

³ (C) = Attestation

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

Core Attribute #2: Accountability <i>“Take responsibility for making sure we receive the best possible health care.”</i>				
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. ⁴ (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 <i>“Provide or help us get the health care, information, and services we need.”</i>				
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). ⁵ (C)	N/A	N/A

⁴ See Table 2 for the list of PCPCH Quality measures.

⁵ 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>.

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

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 has a 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 directly collaborates or co-manages patients with specialty mental health, substance abuse, or developmental providers. (C)	3.C.3 PCPCH is co-located, either actually or virtually, with specialty mental health, substance abuse, or developmental providers. (C)
3.D) Comprehensive Health Assessment & Intervention	N/A	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. (C)	N/A	N/A

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

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	N/A	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	N/A	4.B.3 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

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

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 <i>“Help us navigate the health care system to get the care we need in a safe and timely way.”</i>				
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. ⁶ (C) 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. ⁷ (C)	N/A	N/A

⁶ This could be achieved through use of a panel management system and/or registry.

⁷ 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.

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

Standard	PCPCH Point Tier			
	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
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 be “meaningful users” of the certified electronic health record, according to the Centers for Medicare and Medicaid Services 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
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. (C)	N/A	N/A

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

Standard	PCPCH Point Tier			
	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
5.E) Referral & Specialty Care Coordination	N/A	<p>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. (C)</p> <p>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)</p>	N/A	<p>5.E.3 PCPCH tracks referrals, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians, and coordinates care where appropriate for community settings outside the PCPCH. Coordination must include hospital or skilled nursing facility care as well as other community settings such as dental, educational, social service, foster care, public health, or long term care settings. (C)</p>

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

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 offers or coordinates hospice and palliative care and counseling for patients and families who may benefit from these services. (C)	N/A	N/A	N/A

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

Core Attribute #6: Person- and Family-Centered Care <i>“Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”</i>				
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 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. (C)	N/A	N/A	N/A
6B) Education & Self-Management Support	N/A	6.B.1 PCPCH <u>provides</u> patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. (C)	N/A	N/A

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

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	<p>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, provider communication, coordination of care, and practice staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools. (C)</p>	<p>6.C.2 PCPCH surveys a sample of its population using one of the CAHPS survey tools. (C)</p>	<p>6.C.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools and meets benchmarks on the majority of the domains. (C)</p>

Tables 2.A and 2.B PCPCH Quantitative Data Elements

Table 2.A PCPCH Quality Measures

Measure Title	Adult Core Set	Pediatric Core Set	Menu Set	National Quality Forum⁸ 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
Comprehensive Diabetes Care: HbA1c control	X			NQF0575
Controlling High Blood Pressure	X			NQF0018
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)

⁸ 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.

Tables 2.A and 2.B PCPCH Quantitative Data Elements

Measure Title	Adult Core Set	Pediatric Core Set	Menu Set	National Quality Forum Number
Adolescent well-care (12-21 years)		X		N/A (CHIPRA Core Set Measure #12)
Childhood Immunization Status		X		NQF0038
Use of Appropriate Medications for People with Asthma		X		NQF0036
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)
Blood pressure control for patients 18-75 years with diabetes			X	NQF0061
LDL-C control for patients 18-75 years with diabetes			X	NQF0064
Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)			X	NQF0108

Tables 2.A and 2.B PCPCH Quantitative Data Elements

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)
Blood Pressure Measurement			X	NQF0013
Diabetes: Lipid profile			X	NQF0063

Table 2.B Additional PCPCH Quantitative Measures

PCPCH Standard	Tier 1	Tier 2	Tier 3
4.A) Personal Clinician Assigned	PCPCH reports the percentage of active patients assigned a personal clinician and/or team.		PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team.
4.B) Personal Clinician Continuity	PCPCH reports the percent of patient visits with assigned clinician/team.		PCPCH meets a benchmark in the percent of patient visits with assigned clinician/team.

Table 3. Oregon PCPCH Program 2008 NCQA Recognition Requirements

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	Attests to recognition	N/A	N/A
2008 Level 2 NCQA Recognition	N/A	Attests to recognition	N/A
2008 Level 3 NCQA Recognition	N/A	N/A	Attests to recognition
OR Accountability Measure 2.A	Attests to tracking one measure from the core and/or menu set of measures in Table 2.A	Reports two measures from the core set and one from the menu set of measures in Table 2.A	Reports and meets benchmarks on two measures from the core set and one from the menu set of measures in Table 2.A
OR Comprehensive Whole Person Care Measure 3.A	Attests to meeting measure	Attests to meeting measure	Attests to meeting measure
OR Coordination and Integration 5.G	Attests to meeting measure	Attests to meeting measure	Attests to meeting measure

Table 4. Oregon PCPCH Program 2011 NCQA Recognition Requirements

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	Attests to recognition	N/A	N/A
2011 Level 2 NCQA Recognition	N/A	Attests to recognition	N/A
2011 Level 3 NCQA Recognition	N/A	N/A	Attests to recognition
OR Accountability Measure 2.A	Attests to tracking one measure from the core and/or menu set of measures in Table 2.A	Reports two measures from the core set and one from the menu set of measures in Table 2.A	Reports and meets benchmarks on two measures from the core set and one from the menu set of measures in Table 2.A
OR Coordination and Integration 5.G	Attests to meeting measure	Attests to meeting measure	Attests to meeting measure