

Secretary of State  
Certificate and Order for Filing  
**TEMPORARY ADMINISTRATIVE RULES**  
A Statement of Need and Justification accompanies this form.

I certify that the attached copies\* are true, full and correct copies of the TEMPORARY Rule(s) adopted on October 1, 2011, by the

Date prior to or same as filing date

**Oregon Health Authority, Office for Oregon Health Policy and Research**  
Agency and Division

**409**

Administrative Rules Chapter Number

**Zarie Haverkate**  
Rules Coordinator

**1225 Ferry Street SE, 1<sup>st</sup> Floor, Salem, OR 97301**  
Address

**503-373-1574**  
Telephone

to become effective [ October 1, 2011 ] through [ March 15, 2012 ].

Date upon filing or later A maximum of 180 days including the effective date.

**RULE CAPTION**

**Temporary Adoption of Patient-Centered Primary Care Home Program Rules**

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

**RULEMAKING ACTION**

List each rule number separately, 000-000-0000.

Secure approval of new rule numbers (Adopted rules) with the Administrative Rules Unit prior to filing

ADOPT: OAR 409-055-0000, 409-055-0010, 409-055-0020, 409-055-0025<sup>36</sup>, 409-055-0030<sup>40</sup>, 409-055-0040<sup>50</sup>, 409-055-0060, 409-055-0070, and 409-055-0080 *et al 9/28/11*

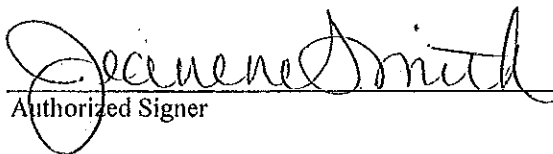
Stat. Auth.: ORS 413.032, 442.210 & 2011 OL, Chapter 602 (HB 3650)

Stats. Implemented: 413.032, 442.210 & 2011 OL, Chapter 602 (HB 3650)

**RULE SUMMARY**

The Oregon Health Authority, Office for Oregon Health Policy and Research is adopting temporary administrative rules for the Patient-Centered Primary Care Home (PCPCH) Program. The rules implement PCPCH standards, reporting, and recognition process and other applicable mandates of ORS 442.210, which was enacted by the 74th Legislative Assembly and 2011 Oregon Laws, Chapter 602 (HB 3650) enacted by the 75<sup>th</sup> Legislative Assembly. These proposed rules are intended to fulfill the mandates by prescribing the standards used for practices to quality as PCPCHs, the reporting requirements for PCPCHs, and the process used to recognize PCPCHs.

These temporary rules are available on the OHPR Website: <http://www.oregon.gov/OHA/OHPR/rulemaking/index.shtml>. For hardcopy requests, call: (503) 373-1574.



Jeanene Smith, MD, Authorized Signer

9/28/11

Authorized Signer

Printed name

Date

\*With this original and Statement of Need, file one photocopy of certificate, one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules. ARC 940-2005

**STATEMENT OF NEED AND JUSTIFICATION**

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

**Oregon Health Authority, Office for Oregon Health Policy and Research**

**409**

Agency and Division

Administrative Rules Chapter Number

In the Matter of: The temporary adoption of OAR 409-055-0000, 409-055-0010, 409-055-0020, 409-055-0030, 409-055-0040, 409-055-0050, 409-055-0060, 409-055-0070, and 409-055-0080.

Rule Caption: (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

Temporary Adoption of Patient-Centered Primary Care Home Program Rules

Statutory Authority: ORS 413.042, 442.210 & 2011 OL, Chapter 602 (HB 3650)

Stats. Implemented: ORS 413.042, 442.210 & 2011 OL, Chapter 602 (HB 3650)

Need for the Temporary Rule(s):

The Oregon Health Authority (OHA), Office for Oregon Health Policy and Research (OHPR) is adopting temporary administrative rules for the Patient-Centered Primary Care Home (PCPCH) Program. The rules implement PCPCH standards, reporting, and recognition process and other applicable mandates of ORS 442.210, enacted by the 74th Legislative Assembly and 2011 Oregon Laws, Chapter 602 (HB 3650) enacted by the 75<sup>th</sup> Legislative Assembly. These proposed rules are intended to fulfill the mandates by prescribing the standards used for practices to qualify as PCPCHs, the reporting requirements for PCPCHs, and the process used to recognize PCPCHs.

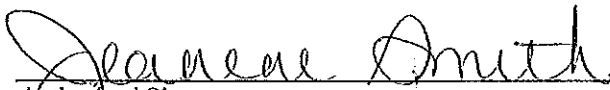
Documents Relied Upon, and where they are available:

The Patient-Centered Primary Care Home Implementation Guide (accessed September 27, 2011):

[http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/docs/Guide\\_August2011.pdf](http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/docs/Guide_August2011.pdf).

Justification of Temporary Rule(s):

The OHA needs to file this rule promptly to allow the OHA to be eligible and accept enhanced federal Medicaid matching funds for individuals receiving care through a PCPCH per Section 2703 of the Affordable Care Act (ACA). Failure to act promptly will result in serious prejudice to the public interest, the Oregon Health Authority, and PCPCH providers. These rules need to be adopted promptly so that OHPR may recognize PCPCHs in order to allow for an additional federal funding stream. These rules also need to be adopted promptly so that PCPCHs know the requirements and process for being recognized as a PCPCH so that they apply for recognition beginning October 1, 2011, the effective date of the Medicaid State Plan Amendment corresponding to Section 2703 of the ACA.



Jeanene Smith, MD, Authorized Signer

9/28/11

Authorized Signer

Printed name

Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 945-2005

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

**DIVISION 55  
PATIENT-CENTERED PRIMARY CARE HOME PROGRAM**

**409-055-0000**

**Scope**

These rules (OAR 409-055-0000 to 409-055-0080) establish the Patient-Centered Primary Care Home Program and define criteria 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, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

**409-055-0010**

**Definitions**

The following definitions apply to OAR 409-055-0000 to 409-055-0080:

- (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 2011 OL Chapter 602 (HB 3650), meets the standards pursuant to OAR 409-055-0030, and has been recognized through the process pursuant to OAR 409-055-0040.

## TEMPORARY ADOPT

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- (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 supplies 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 <http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/index.shtml>.
- (12) “Provider” means an individual, facility, institution, corporate entity, or other organization which supplies 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, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

### **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 Office shall recognize practices as PCPCHs upon meeting defined criteria through the Program.

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

Stat. Auth: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

#### **409-055-0030**

##### **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 409-055-0040.
- (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.
- (10) Measure specification, thresholds for demonstrating improvement, and benchmarks for quantitative data elements shall be developed by the Office and made available on the Program website.
- (11) NCQA recognition will be acknowledged in the Authority's Patient Centered Medical Home (PCMH) recognition process.
- (12) Depending on the version of NCQA recognition that was used, practices seeking Oregon PCPCH recognition must attest to being a NCQA recognized PCMH and submit additional information.
- (13) Additional required elements 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, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

#### **409-055-0040**

##### **Recognition Process**

- (1) The Office shall develop a web-based reporting process where practices or other entities on behalf of the practice shall submit data per OAR 409-055-0030. Based on the data submitted by a practice and the criteria in OAR 409-055-0030, the Office shall assign a Tier level to each recognized practice.
- (2) The Office shall keep instructions for submitting data posted on the Program website.
- (3) Practices shall be notified of a PCPCHs Tier score within 60 days of complete data submission.
- (4) Practices must file a request for review with the Program within 180 days if the practice disagrees with the calculated Tier score.
- (5) PCPCHs must renew their recognition annually. 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 not more than once every six months.
- (6) Recognition requests may be sent to: [PCPCH@state.or.us](mailto: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

Stat. Auth: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

**409-055-0050**

**Data Reporting Requirements for Recognized PCPCHs**

- (1) In order to be recognized as a PCPCH, a practice must attest to meeting certain standards as well as submit quantitative data elements as described in Tables 1 and 2.
- (2) The attestation shall be submitted via the web-based process pursuant to OAR 409-055-0040.
- (3) Recognized PCPCHs shall be scored and tiered pursuant to OAR 409-055-0030.
- (4) Attestation data must be submitted by PCPCHs once every three years 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 via the web-based reporting process.
- (7) Quantitative data elements selected from Table 2 must be submitted by recognized PCPCHs annually.
- (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.

Stat. Auth: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

**409-055-0060**

**Compliance and Enforcement**

- (1) The Office shall conduct a random audit of a select percentage of PCPCH applicants to verify reported attestation and quantitative data elements for the purposes for confirming recognition and Tier level.

- (2) Practices selected for verification shall be notified no less than 30 days prior to the scheduled audit.
- (3) Verification may include an audit of practice process as well as medical chart review.
- (4) If the Office finds that the practice is not in compliance with processes as attested to, the Office shall work with the practice to move into compliance.
- (5) If a practice fails to move into compliance within 180 days of identification of non-compliance with attested information, the Office shall amend the practice's PCPCH recognition to reflect the appropriate Tier level

Stat. Auth: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

**409-055-0070**

**Insurance Carrier and Managed Care Plan Communication**

- (1) The Office shall develop a system for making recognized PCPCH Tier status available to insurance carriers and managed care organizations.
- (2) The Office shall maintain and update monthly the recognized PCPCH Tier status lists.

Stat. Auth: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

**409-055-0080**

**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 Office 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, 442.210 & 2011 OL Chapter 602 (HB 3650)

Stat. Implemented: ORS 413.042, 442.210 & 2011 OL Chapter 602 (HB 3650)

TEMPORARY ADOPT

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
<b>1.A) In-Person Access</b>	N/A	<b>1.A.1</b> PCPCH surveys a sample of its population on satisfaction with in-person access to care and reports results. (C) <sup>1</sup>	<b>1.A.2</b> PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools <sup>2</sup> and reports results on the access to care domain. (C)	<b>1.A.3</b> 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. (C)
<b>1.B) After Hours Access</b>	N/A	<b>1.B.1</b> PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours. (C) <sup>3</sup>	N/A	N/A
<b>1.C) Telephone &amp; Electronic Access</b>	<b>1.C.0</b> PCPCH provides continuous access to clinical advice by telephone. (C)	N/A	N/A	N/A

<sup>1</sup> D = Quantitative data report

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

<sup>3</sup> C = Attestation

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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
<b>2.A) Performance &amp; Clinical Quality Improvement</b>	<b>2.A.0</b> PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures. <sup>4</sup> (C)	N/A	<b>2.A.2</b> PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D)	<b>2.A.3</b> 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>				
<b>3.A) Preventive Services</b>	N/A	<b>3.A.1</b> PCPCH offers or coordinates 90% of recommended preventive services (Grade A or B USPTF and/or Bright Futures periodicity guideline). <sup>5</sup> (C)	N/A	N/A

<sup>4</sup> See Table 2 for the list of PCPCH Quality measures.

<sup>5</sup> 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>.

TEMPORARY ADOPT

**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
<b>3.B) Medical Services</b>	<b>3.B.0</b> 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
<b>3.C) Mental Health, Substance Abuse, &amp; Developmental Services</b>	<b>3.C.0</b> PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources. (C)	N/A	<b>3.C.2</b> PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers. (C)	<b>3.C.3</b> PCPCH documents actual or virtual co-location with specialty mental health, substance abuse, or developmental providers. (C)
<b>3.D) Comprehensive Health Assessment &amp; Intervention</b>	N/A	<b>3.D.1</b> PCPCH documents comprehensive health assessment and intervention for at least three health risk or developmental promotion behaviors. (C)	N/A	N/A

TEMPORARY ADOPT

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
<b>4.A) Personal Clinician Assigned</b>	<b>4.A.0</b> PCPCH reports the percentage of active patients assigned a personal clinician and/or team. (D)	N/A	<b>4.A.2</b> PCPCH demonstrates improvement on the percentage of active patients assigned to a personal clinician and/or team. (D)	<b>4.A.3</b> PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team. (D)
<b>4.B) Personal Clinician Continuity</b>	<b>4.B.0</b> PCPCH reports the percent of patient visits with assigned clinician/team. (D)	N/A	<b>4.B.2</b> PCPCH demonstrates improvement in the percent of patient visits with assigned clinician/team. (D)	<b>4.B.3</b> PCPCH meets a benchmark in the percent of patient visits with assigned clinician/team. (D)
<b>4.C) Organization of Clinical Information</b>	<b>4.C.0</b> 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	N/A	N/A	N/A

TEMPORARY ADOPT

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

	needed at each visit. (C)			
Standard	PCPCH Point Tier			
	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
<b>4.D) Clinical Information Exchange</b>	N/A	N/A	N/A	<b>4.D.3</b> PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). (C)
<b>4.E) Specialized Care Setting</b>	<b>4.E.0</b> PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (C)	N/A	N/A	N/A
<b>Core Attribute #5: Coordination &amp; Integration</b> <i>“Help us navigate the health care system to get the care we need in a safe and timely way.”</i>				
<b>5.A) Population Data Management</b>	N/A	<b>5.A.1a</b> PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population. <sup>6</sup> (C)	N/A	N/A

<sup>6</sup> This could be achieved through use of a panel management system and/or registry.  
OAR 409-055-0000 to 409-055-0080

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**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
<b>5.A) Population Data Management</b> <i>(continued)</i>	N/A	<b>5.A.1b</b> 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. <sup>7</sup> (C)	N/A	N/A
<b>5.B) Electronic Health Record</b>	N/A	N/A	N/A	<b>5.B.3</b> PCPCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules. (C)
<b>5.C) Care Coordination</b>	N/A	<b>5.C.1</b> 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)	<b>5.C.2</b> PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (C)	N/A

<sup>7</sup> 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.

OAR 409-055-0000 to 409-055-0080

TEMPORARY ADOPT

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
<b>5.D) Test &amp; Result Tracking</b>	N/A	<b>5.D.1</b> 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
<b>5.E) Referral &amp; Specialty Care Coordination</b>	N/A	<b>5.E.1a</b> 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)  <b>5.E.1b</b> 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	<b>5.E.3</b> 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)

TEMPORARY ADOPT

**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
<b>5.F) Comprehensive Care Planning</b>	N/A	N/A	<b>5.F.2</b> 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
<b>5.G) End of Life Planning</b>	<b>5.G.0</b> PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from	N/A	N/A	N/A

TEMPORARY ADOPT

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

	these services. (C)			
<b>Core Attribute #6: Person- and Family-Centered Care</b> <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>				
<b>Standard</b>	<b>PCPCH Point Tier</b>			
	<b>Must-Pass ✓</b>	<b>Tier 1 5 points each</b>	<b>Tier 2 10 points each</b>	<b>Tier 3 15 points each</b>
<b>6A) Language / Cultural Interpretation</b>	<b>6.A.0</b> 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
<b>6B) Education &amp; Self-Management Support</b>	N/A	<b>6.B.1</b> PCPCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. (C)	N/A	N/A

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**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
<b>6C) Experience of Care</b>	N/A	<b>6.C.1</b> 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 or health team communication, helpfulness of office staff, and overall provider or health team rating. The recommended patient experience of care survey is one of the CAHPS survey tools. (C)	<b>6.C.2</b> PCPCH surveys a sample of its population using one of the CAHPS survey tools and reports results on the access to care domain. (C)	<b>6.C.3</b> 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. (C)

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**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 Forum <sup>8</sup> Number
<b>Adult Weight Screening and Follow-up</b>	X			NQF0421
<b>Medical Assistance With Smoking and Tobacco Use Cessation</b>	X			NQF0028
<b>Breast cancer screening</b>	X			NQF0031
<b>Cervical cancer screening</b>	X			NQF0032
<b>Colorectal cancer screening</b>	X			NQF0034
<b>Hemoglobin A1c testing</b>	X			NQF0057
<b>Body Mass Index (BMI) Percentile</b>		X		NQF0024
<b>Asthma Assessment</b>		X		NQF0001
<b>Developmental screening &lt; 3 years old</b>		X		N/A
<b>Well child care (0 – 15 months)</b>		X		N/A (CHIPRA Core Set Measure #10)
<b>Well child care (3 – 6 years)</b>		X		N/A (CHIPRA Core Set Measure #11)
<b>Adolescent well-care (12-21 years)</b>		X		N/A (CHIPRA Core Set Measure #12)

<sup>8</sup> 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.

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

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

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**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)
Childhood Immunization Status			X	NQF0038
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
<b>4.A) Personal Clinician Assigned</b>	PCPCH reports the percentage of active patients assigned a personal clinician and/or team.	PCPCH demonstrates improvement on the percentage of active patients assigned to a personal clinician and/or team.	PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team.
<b>4.B) Personal Clinician Continuity</b>	PCPCH reports the percent of patient visits with assigned clinician/team.	PCPCH demonstrates improvement in the percent of patient visits with assigned clinician/team.	PCPCH meets a benchmark in the percent of patient visits with assigned clinician/team.

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**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 demonstrates improvement or 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 demonstrates improvement or 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