2017 PCPCH Standards - NCQA PCMH 2017 Standards - Crosswalk

Key Differences between NCQA-PCMH and PCPCH:

1. PCMH has no tiers/level of recognition – Either you are recognized or not. PCPCH has 5 tiers of recognition.
2. PCMH has 40 required (core) standards, PCPCH has 11 must-pass standards.
3. PCMH has 60 optional standards either worth 1 or 2 credits, you must receive at least 25 credits to be recognized. PCPCH has optional measures worth 5, 10 or 15 points, your tier depends on how many of these optional standards your clinic attests to.

Oregon PCPCH 2017 Standards	**NCQA PCMH 2017**	**Key Differences**
PCPCH Core Attribute 1: Access to Care Standard 1.A: In-Person Access 1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care. 1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care. 1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.	AC 01 (Core): Assesses the access needs and preferences of the patient population. (New) QI 04 (Core): Monitors patient experience through: A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as: • Access. • Communication. • Coordination. • Whole-person care, self-management support and comprehensiveness. B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means. QI 06 (1 Credit): The practice uses a standardized, validated patient experience survey tool with benchmarking data available. QI 11 (Core): Sets goals and acts to improve performance on at least one patient experience measure.	This is a required standard for PCMH and an optional one for PCPCH. PCMH requires that the clinic evaluate the results to determine if existing access methods are sufficient for its population. PCMH requires that the clinic obtain patient feedback through qualitative means. PCMH does not require or recommend CAHPS as a survey tool, PCPCH recommends it and requires its use to get credit for parts of 1A and 6A. PCMH requires that goals and actions to improve be set around one patient experience measure. PCMH also requires the clinic to assess performance of access by tracking a measure like 3rd next available appt. (see PCMH Q1 03) .

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PCPCH Core Attribute 1: Access to Care Standard 1.B: After Hours Access 1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	AC 03 (Core): Provides routine and urgent appointments outside regular business hours to meet identified patient needs.	This is a required standard for PCMH and an optional one for PCPCH.
PCPCH Core Attribute 1: Access to Care Standard 1.C: Telephone & Electronic Access (Must-pass) 1.C.0 PCPCH provides continuous access to clinical advice by telephone.	AC 04 (Core): Provides timely clinical advice by telephone AC 05 (Core): Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record. AC 08 (1 Credit): Has a secure electronic system for two-way communication to provide timely clinical advice. AC 12 (2 Credits): Provides continuity of medical record information for care and advice when the office is closed.	Both models require continuous access to clinical advice, PCMH has an additional requirement that clinical advice and care provided after-hours does not conflict with patient's medical record. PCMH model has optional standard related to secure electronic system for clinical advice. PCPCH recommends that the person giving clinical advice have access to the patient's medical record but it is not required. For PCMH AC 12 it is required to have access to the patient's medical record to get credit for this optional standard.
PCPCH Core Attribute 1: Access to Care Standard 1.D: Same Day Access 1.D.1 PCPCH provides same day appointments.	AC 02 (Core): Provides same-day appointments for routine and urgent care to meet identified patient needs.	This is a required standard for PCMH and an optional one for PCPCH.
PCPCH Core Attribute 1: Access to Care Standard 1.E Electronic Access	AC 07 (1 Credit): Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results.	The PCPCH model's electronic access standard is about patient being able to get an e-copy of their health information. The PCMH model's standard is about the patient

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1.E.1 PCPCH provides patients with an electronic copy of their health information upon request using a method that satisfies either Stage 1 or Stage 2 Meaningful Use measures.		being able to request appointments, prescription refills, referrals and test results.
PCPCH Core Attribute 1: Access to Care Standard 1.F: Prescription Refills 1.F.2 PCPCH tracks the time to completion for prescription refills. 1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	No PCMH standard	There is a PCMH standard (AC 07) around having a secure electronic system for patient to request refills but nothing in model about tracking refills or improvement on refill performance.
PCPCH Core Attribute 2: Accountability Standard 2.A : Performance & Clinical Quality 2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures. (Must-Pass) 2.A.1 PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D) 2.A.2 PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D) 2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	QI 02 (Core): Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): A. Measures related to care coordination. B. Measures affecting health care costs. QI 03 (Core): Assesses performance on availability of major appointment types to meet patient needs and preferences for access. QI 10 (Core): Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences. QI 09 (Core): Sets goals and acts to improve performance on at least one measure of resource stewardship: A. Measures related to care coordination. B. Measures affecting health care costs. ‘ QI 12 (2 Credits): Achieves improved performance on at least two performance measures.	PCPCH requires that only 1 quality metric be tracked. PCMH requires all of these to be tracked and that a subset of each type also have goals and activities to improve on their performance. 1. 5 clinical quality measures across 4 categories (The behavioral health category is new for PCMH) 2. 1 measure related to care coordination 3. 1 measure affecting health care cost 4. 1 access measure (like 3rd next available appt) PCPCH has optional standard around meeting benchmarks. PCMH gives credit for achieving improved performance but not for reaching specific benchmarks.

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PCPCH Core Attribute 2: Accountability Standard 2.B: Public Reporting 2.B.1 PCPCH participates in a public reporting program for performance indicators. 2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	QI 15 (Core): Reports practice-level or individual clinician performance results within the practice for measures reported by the practice. QI 16 (1 Credit): Reports practice-level or individual clinician performance results publicly or with patients for measures reported by the practice. QI 18 (2 Credits): Reports clinical quality measures to Medicare or Medicaid agency.	PCPCH is specific to publicly reported data and not required. QI 15 -PCMH is about any clinical performance data and is required.
PCPCH Core Attribute 2: Accountability Standard 2.C: Patient and Family Involvement in Quality Improvement 2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year. 2.C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development and/or educational improvement activities. 2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	QI 17 (2 Credits): Involves patient/family/caregiver in quality improvement activities. TC 04 (2 Credits): Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.	No PCMH standard regarding integrating patient, caregiver and family-advisors into the practice and functioning in peer-support or training roles.
PCPCH Core Attribute 2: Accountability Standard 2.D : Quality Improvement 2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	QI 01 (Core): Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type): A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures.	PCMH has an optional standard specific to using feedback from vulnerable patient groups in QI. In PCMH, it is required to involve care team staff in quality improvement and performance evaluation.

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2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress. 2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	QI 07 (2 Credits): The practice obtains feedback on experiences of vulnerable patient groups. QI 08 (Core): Sets goals and acts to improve upon at least three measures across at least three of the four categories: A. Immunization measures. B. Other preventive care measures. C. Chronic or acute care clinical measures. D. Behavioral health measures. TC 07 (Core): Involves care team staff in the practice's performance evaluation and quality improvement activities.	
PCPCH Core Attribute 2: Accountability Standard 2.E: Ambulatory Sensitive Utilization 2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population. 2.E.2 - PCPCH tracks selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization. 2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	CC 14 (Core): Systematically identifies patients with unplanned hospital admissions and emergency department visits. CC 16 (Core): Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	In PCMH, practices are required to identify and monitor patients with unplanned hospital and ED visits. In PCMH, practices are required to follow up with patients after hospital admission or ED visit.
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.A : Preventive Services 3.A.1 PCPCH routinely offers or coordinates recommended preventive services appropriate for your population (i.e. age	KM 12 (Core): Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories): A. Preventive care services. B. Immunizations. C. Chronic or acute care services.	

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and gender) based on best available evidence and identifies areas for improvement. 3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population. 3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	D. Patients not recently seen by the practice.	
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.B: Medical Services 3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support. (Must-Pass)	No PCMH standard	
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.C : Behavioral Health Services 3.C.0 PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site, local referral resources and processes. (Must-Pass) 3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers.	KM 03 (Core): Conducts depression screenings for adults and adolescents using a standardized tool. KM 04 (1 Credit): Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression.	

Oregon PCPCH 2017 Standards	NCQA PCMH 2017	Key Differences
3.C.3 PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.	TC 08 (2 Credits) Has at least one care manager qualified to identify and coordinate behavioral health needs. CC 09 (2 Credits): Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care. CC 10 (2 Credits): Integrates behavioral healthcare providers into the care delivery system of the practice site.	
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.D : Comprehensive Health Assessment & Intervention 3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	KM 02 (Core): Comprehensive health assessment includes (all items required): A. Medical history of patient and family. B. Mental health/substance use history of patient and family. C. Family/social/cultural characteristics. D. Communication needs. E. Behaviors affecting health. F. Social functioning. G. Social determinants of health. H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices.)	In PCMH, comprehensive health assessments are required.
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.E - Preventive Service Reminders 3.E.1 PCPCH sends reminders to patients for preventative/follow-up care using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. 3.E.2 PCPCH uses patient information, clinical data and evidence-based guidance to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders.	KM 12 (Core): Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories): A. Preventive care services. B. Immunizations. C. Chronic or acute care services. D. Patients not recently seen by the practice.	

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3.E.3 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services.		
PCPCH Core Attribute 4: Continuity Standard 4.A : Personal Clinician Assigned 4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D) (Must-pass) 4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	AC 10 (Core): Helps patients/families/ caregivers select or change a personal clinician.	PCMH requires that patients be assigned to clinician or care team, given information about importance of having personal clinician or care team and that the clinic assists in selection process. PCPCH only requires that clinic report % of patients with assignment to personal clinician or care team.
PCPCH Core Attribute 4: Continuity Standard 4.B: Personal Clinician Continuity 4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D) (Must-pass) 4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	AC 11 (Core): Sets goals and monitors the percentage of patient visits with the selected clinician or team.	PCMH requires that the practice set a goal for the % of visits with assigned clinician or team. PCPCH does not require clinics to set a goal for the must pass standard but for 4.B.2 requires them to track and improve and for 4.B.3 meet a benchmark.
PCPCH Core Attribute 4: Continuity Standard 4.C : Organization of Clinical Information	KM 01 (Core): Documents an up-to-date problem list for each patient with current and active diagnoses. KM 02 (Core): Comprehensive health assessment includes (all items required): A. Medical history of patient and family.	The PCMH requirements under KM 02 go well beyond what is required for PCPCH to be collected for every patient. Also under PCPCH 3D.

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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. (Must Pass)	B. Mental health/substance use history of patient and family. C. Family/social/cultural characteristics. D. Communication needs. E. Behaviors affecting health. F. Social functioning. G. Social determinants of health. H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices.)	
PCPCH Core Attribute 4: Continuity Standard 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).	CC 15 (Core): Shares clinical information with admitting hospitals and emergency departments. CC 18 (1 Credit): Exchanges patient information with the hospital during a patient's hospitalization. CC 19 (1 Credit): Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities.	In PCMH, practices are required to share clinical information with hospitals and EDs, in PCPCH it is an optional standard.
PCPCH Core Attribute 4: Continuity Standard 4.E: Specialized Care Setting Transitions 4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (Must-pass)	CC 08 (1 Credit): Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care. CC 12 (1 Credit): Documents co-management arrangements in the patient's medical record.	In PCMH, there is no required written hospital agreement.
PCPCH Core Attribute 4: Continuity Standard 4.F: Planning for Continuity 4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	No PCMH standard	

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PCPCH Core Attribute 4: Continuity Standard 4.G: Medication Reconciliation and Management 4.G.1. Upon receipt of a patient from another setting of care or provider of care (transitions of care), the PCPCH performs medication reconciliation using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. 4.G.2 PCPCH develops a process, tracks and reports the percentage of patients whose medication regimen is reconciled at each relevant patient encounter. 4.G.3 PCPCH provides Comprehensive Medication Management for appropriate patients and families.	KM 14 (Core): Reviews and reconciles medications for more than 80 percent of patients received from care transitions. KM 15 (Core): Maintains an up-to-date list of medications for more than 80 percent of patients.	In PCMH, medication reconciliation is required for more than 80% of patient during transitions of care in PCPCH it is optional.
PCPCH Core Attribute 5: Coordination and Integration Standard 5.A : Population Data Management 5.A.1 PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its patient population, including the identification of sub-populations. 5.A.2 PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior.	QI 05 (1 Credit): Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A. Clinical quality. B. Patient experience. QI 13 (1 Credit): Sets goals and acts to improve disparities in care or services on at least one measure. KM 06 (1 Credit): Identifies the predominant conditions and health concerns of the patient population. KM 07 (2 Credits): Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data. KM 11 (1 Credit): Identifies and addresses population-level needs based on the diversity of the practice and the community (demonstrate at least two): A. Target population health management on disparities in care. B. Address health literacy of the practice staff. C. Educate practice staff in cultural competence.	PCMH gives credit for identifying sub-populations based on vulnerable populations in terms of health disparities and social determinants of health. Also credit given for identifying the predominant conditions and concerns in patient population. In PCMH, a systematic care management process is required.

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	CM 01 (Core): Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions. B. High cost/high utilization. C. Poorly controlled or complex conditions. D. Social determinants of health. E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver. CM 02 (Core): Monitors the percentage of the total patient population identified through its process and criteria. CM 03 (2 Credits): Applies a comprehensive risk- stratification process for the entire patient panel in order to identify and direct resources appropriately.	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.B : Electronic Health Record 5.B.3 PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be "meaningful users" of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	TC 05 (2 Credits): The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies.	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.C : Complex Care Coordination 5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member(s) responsible for coordinating his or her care.	CM 04 (Core): Establishes a person-centered care plan for patients identified for care management. CM 05 (Core): Provides a written care plan to the patient/family/caregiver for patients identified for care management. CM 06 (1 Credit): Documents patient preference and functional/lifestyle goals in individual care plans.	In PCMH a written care plan is required for patient identified for care management. This is an optional standard in PCPCH.

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5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. 5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.	CM 07 (1 Credit): Identifies and discusses potential barriers to meeting goals in individual care plans. CM 08 (1 Credit): Includes a self-management plan in individual care plans. CM 09 (1 Credit): Care plan is integrated and accessible across settings of care. CC 20 (1 Credit): Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).	
PCPCH Core Attribute 5: Coordination and Integration Standard 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.	CC 01 (Core): The practice systematically manages lab and imaging tests by: A. Tracking lab tests until results are available, flagging and following up on overdue results. B. Tracking imaging tests until results are available, flagging and following up on overdue results. C. Flagging abnormal lab results, bringing them to the attention of the clinician. D. Flagging abnormal imaging results, bringing them to the attention of the clinician. E. Notifying patients/families/caregivers of normal lab and imaging test results. F. Notifying patients/families/caregivers of abnormal lab and imaging test results. CC 02 (1 Credit): Follows up with the inpatient facility about newborn hearing and blood-spot screening. CC 03 (2 Credits): Uses clinical protocols to determine when imaging and lab tests are necessary.	Tracking lab and imaging tests is a required standard in PCMH. This is an optional standard in PCPCH.
PCPCH Core Attribute 5: Coordination and Integration Standard 5.E: Referral & Specialty Care Coordination 5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	KM 25 (1 Credit): Engages with schools or intervention agencies in the community. (New) CC 04 (Core): The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical question, the required timing and the type of referral. B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.	In PCMH, managing referrals is required. This is an optional standard in PCPCH.

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5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility). 5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.	C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. CC 05 (2 Credits): Uses clinical protocols to determine when a referral to a specialist is necessary. CC 06 (1 Credit): Identifies the specialists/specialty types frequently used by the practice. CC 07 (2 Credits): Considers available performance information on consultants/specialists when making referrals. CC 11 (1 Credit): Monitors the timeliness and quality of the referral response.	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.F : End of Life Planning 5.F.O PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (Must-pass) 5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients' opt out).	KM 02 (Core): Comprehensive health assessment includes (all items required): A. Medical history of patient and family. B. Mental health/substance use history of patient and family. C. Family/social/cultural characteristics. D. Communication needs. E. Behaviors affecting health. F. Social functioning. G. Social determinants of health. H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices.)	PCMH requires that advance care planning be included in the comprehensive health assessment for every patient except for pediatric practices. PCPCH requires the practice to offer or coordinate end of life planning activities.
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.A: Language/Cultural Interpretation 6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice. (Must-Pass)	KM 10 (Core): Assesses the language needs of its population. KM 08 (1 Credit): Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials. (New)	PCMH includes health literacy, communication preferences and demographics other than language in development and distribution of patient materials.

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6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.		
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.B - Education & Self-Management Support 6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate. 6.B.2 More than 10% of unique patients are provided patient-specific education resources. 6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	KM 21 (Core): Uses information on the population served by the practice to prioritize needed community resources. KM 22 (1 Credit): Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs. KM 26 (1 Credit): Routinely maintains a current community resource list based on the needs identified in KM 21. KM 27 (1 Credit): Assesses the usefulness of identified community support resources.	PCMH gives credit for assessing usefulness of community resources which is not included in the PCPCH model. PCMH requires that practice use information on the population served to prioritize resources. This is optional in PCPCH model.
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.C: Experience of Care 6.C.0 PCPCH surveys a sample of its patients and families at least at least every two years on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools. (Must-pass) 6.C.2 – PCPCH surveys a sample of its population at least every two years on their experience of care using of one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process.	QI 04 (Core): Monitors patient experience through: A. Quantitative data. Conducts a survey (using any instrument) to evaluate patient/family/caregiver experiences across at least three dimensions such as: • Access. • Communication. • Coordination. • Whole-person care, self-management support and comprehensiveness. B. Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means.	PCMH has a broader definition of how to get patient feedback regarding experience of care. They accept not just surveys, like in PCPCH, but also patient interviews, comment box, other methods. They do not mention CAHPS. PCMH also requires that the clinic obtain patient feedback through qualitative means as well as quantitative means. PCPCH does not require this.

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6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using of one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process and meets benchmarks on the majority of domains regarding provider communication, coordination of care, and practice staff helpfulness.		
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.D: Communication of Rights, Roles, and Responsibilities 6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	TC 09 (Core): Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.	Required in PCMH and optional in PCPCH.
NOT IN PCPCH MODEL	**Telemedicine/Telehealth** AC 06 (1 Credit): Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms.	.
NOT IN PCPCH MODEL	**Panel Management** AC 13 (1 Credit): Reviews and actively manages panel sizes. (New) AC 14 (1 Credit): Reviews and reconciles panels based on health plan or other outside patient assignments. (New)	
NOT IN PCPCH MODEL	**Health Disparities in Vulnerable Populations** QI 05 (1 Credit): Assesses health disparities using performance data stratified for vulnerable populations (must choose one from each section): A. Clinical quality. B. Patient experience. QI 13 (1 Credit): Sets goals and acts to improve disparities in care or services on at least one measure.	

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	QI 14 (2 Credits): Achieves improved performance on at least one measure of disparities in care or service. AC 09 (1 Credit): Uses information about the population served by the practice to assess equity of access that considers health disparities. (New) KM 09 (Core): Assesses the diversity (race, ethnicity, and one other aspect of diversity) of its population.	
NOT IN PCPCH MODEL	**Value Based Agreements** QI 19 (*Maximum* 2 Credits): Is engaged in Value-Based Agreement. (New) A. Practice engages in upside risk contract (1 Credit). B. Practice engages in two-sided risk contract (2 Credits).	
NOT IN PCPCH MODEL	**Activities related to being a PCMH** TC 01 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities. TC 02 (Core): Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions. TC 03 (1 Credit): The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).	
NOT IN PCPCH MODEL	**EHR** TC 05 (2 Credits): The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies.	
NOT IN PCPCH MODEL	**Communications in Teams** TC 06 (Core): Has regular patient care team meetings or a structured communication process focused on individual patient care.	
NOT IN PCPCH MODEL	**Oral Health Related**	

Oregon PCPCH 2017 Standards	NCQA PCMH 2017	Key Differences
	KM 05 (1 Credit): Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners. KM 23 (1 Credit): Provides oral health education resources to patients. (New)	
NOT IN PCPCH MODEL	**Medication Related** KM 16 (1 Credit): Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregiver. KM 17 (1 Credit): Assesses and addresses patient response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment. KM 18 (1 Credit): Reviews controlled substance database when prescribing relevant medications. KM 19 (2 Credits): Systematically obtains prescription claims data in order to assess and address medication adherence.	
NOT IN PCPCH MODEL	**Evidence Based Guidelines** KM 20 (Core): Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria): A. Mental health condition. B. Substance use disorder. C. A chronic medical condition. D. An acute condition. E. A condition related to unhealthy behaviors. F. Well child or adult care. G. Overuse/appropriateness issues. KM 13 (2 Credits): Demonstrates excellence in a benchmarked/ performance-based recognition program assessed using evidence-based care guidelines. (New)	
NOT IN PCPCH MODEL	KM 21 (Core): Uses information on the population served by the practice to prioritize needed community resources.	
NOT IN PCPCH MODEL	KM 24 (1 Credit): Adopts shared decision-making aids for preference-sensitive conditions.	

Oregon PCPCH 2017 Standards	NCQA PCMH 2017	Key Differences
NOT IN PCPCH MODEL	KM 28 (2 Credits): Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists). (New)	
NOT IN PCPCH MODEL	CC 13 (2 Credits): Engages with patients regarding cost implications of treatment options.	
NOT IN PCPCH MODEL	CC 17 (1 Credit): Systematic ability to coordinate with acute care settings after office hours through access to current patient information.	
NOT IN PCPCH MODEL	CC 21 (*Maximum* 3 Credits): Demonstrates electronic exchange of information with external entities, agencies and registries (May select one or more): A. Regional health information organization or other health information exchange source that enhances the practice's ability to manage complex patients. (1 Credit) B. Immunization registries or immunization information systems. (1 Credit) C. Summary of care record to another provider or care facility for care transitions. (1 Credit)	

NCQA PCMH Terms:

PCMH- Patient-Centered Medical Home

TC – Team-Based Care and Practice Organization

KM – Knowing and Managing Your Patients

AC – Patient-Centered Access and Continuity

CM – Care Management and Support

CC – Care Coordination and Care Transitions

QI – Performance Measurement and Quality Improvement

Resource links:

PCPCH 2017 Recognition Criteria - Technical Specifications and Reporting Guide

http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf

For more information about this crosswalk contact PCPCH@state.or.us