

**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, that wish to be recognized as a PCPCH shall submit a PCPCH Recognition Application electronically to the Authority via the Program's online application system found on the Program website or by mail to the address posted on the Program website. The application shall include the quantitative data described in OAR 409-055-0040.
- (2) The Authority shall review the application within 60 days of its submission to determine whether it is accurate, complete, and meets the recognition requirements. If the application is incomplete the applicant will be notified in writing of the information that is missing and when it must be submitted.
- (3) The Authority shall review a complete application within 60 days of submission. If the Authority determines that the applicant has met the requirements of these rules the Authority shall:
 - (a) Inform the applicant in writing that the application has been approved as a recognized PCPCH,
 - (b) Assign a Tier level, and
 - (c) Include the effective recognition date.

- (4) The Authority shall maintain instructions and criteria for submitting a PCPCH Recognition Application posted on the Program website.
- (5) The Authority may deny PCPCH recognition if an applicant does not meet the requirements of these rules.
- (6) A Practice may request that the Authority reconsider the denial of PCPCH recognition or reconsider the assigned tier level. A request for reconsideration must be submitted in writing to the Authority within 90 days of the date of the denial or approval letter and must include a detailed explanation of why the practice believes the Authority's decision is in error along with any supporting documentation. The Authority shall inform the practice in writing whether it has reconsidered its decision.
- (7) Practices submitting applications on or after September 3, 2013 must apply to renew their recognition once every two years. Recognition will expire two years from the effective date of recognition that was issued by the Authority.
 - (a) At the Authority's discretion a 30-day grace period may be allowed for PCPCHs to submit their renewal application without having a lapse in recognition status.
 - (b) If a PCPCH believes that it meets the criteria to be recognized at a higher tier or increase its point threshold by at least 15 points, it may request to have its tier status reassessed by re-submitting an application not more than once every six months. The Authority may grant exceptions to the six month time period for good cause shown.
 - (c) Currently recognized PCPCHs that are due to reapply between September 3, 2013 and December 31, 2013 will be granted a grace period and have the option to wait to submit a renewal application between January 1, 2014 to January 30, 2014 without having a lapse in recognition status.

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 recognition criteria 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 5 point measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay.
- (3) 10 and 15 point measures reflect intermediate and advanced functions.
- (4) Except for the 10 Must-Pass measures, each measure is assigned a point value. A practice must meet the following point allocation criteria to be recognized as a PCPCH:
 - (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) The Authority shall calculate a practice's point score through the recognition process described in OAR 409-055-0030.
- (6) Table 1, incorporated by reference, contains the detailed list of Measures and corresponding point assignments.
- (7) Table 2, incorporated by reference, contains a detailed list of the PCPCH Quality Measures.
- (8) Measure specifications, thresholds for demonstrating improvement, and benchmarks for quantitative data elements are available on the Program website.
- (9) National Committee for Quality Assurance (NCQA) recognition shall 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.
- (10) A practice seeking Oregon PCPCH recognition based on its NCQA recognition must:
 - (a) Submit a PCPCH application and evidence of its NCQA recognition along with its application;
 - (b) Comply with Table 3, incorporated by reference, for NCQA PCMH practices using 2008 NCQA criteria; or
 - (c) Comply with Table 4, incorporated by reference, for NCQA PCMH practices using 2011 NCQA criteria.

- (11) The Authority may designate a practice as a Tier 3 “Star” Patient-Centered Primary Care Home for those practices attesting to a large number of advanced PCPCH criteria. The Authority will determine the criteria for this designation no later than June 2014.

[ED. NOTE: Tables referenced are not included in rule text. [Click here for PDF copy of table\(s\).](#)]

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stats. Implemented: 413.042, 414.655 & 442.210

409-055-0050

Data Reporting Requirements for Recognized PCPCHs

- (1) To be recognized as a PCPCH, a practice must attest to meeting the criteria and submit quantitative data elements to support its attestation in accordance with Tables 1 & 2, incorporated by reference.
- (2) Quantitative data shall be aggregated at the practice level, not the individual patient level, and a practice may not transfer any personal health information to the Authority during the PCPCH application process.
- (3) PCPCHs must submit new quantitative and attestation data as a part of the recognition renewal process and must use the specifications found on the Program website for calculating application data.
- (4) If approved by the practice, other entities may submit information on behalf of a practice, as long as appropriate practice staff has reviewed all application information and data prior to submission.
- (5) A practice may request an exception to any of the quantitative data reporting requirements in Table 2 or the Must-Pass criteria by submitting a form prescribed by the program. The Authority may grant exceptions for good cause shown.
- (6) Practices are required to submit 12 months of quantitative data in order to meet standards 2.A., 4.A., and 4.B. A practice may request an exception to the 12 month data reporting period by submitting a form prescribed by the program. The Authority may grant exceptions for good cause shown.
- (7) The Authority shall notify the practice within 60 days of complete application and exception submission whether or not the requested exception has been granted.

[ED. NOTE: Tables referenced are not included in rule text. [Click here for PDF copy of table\(s\).](#)]

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stats. Implemented: 413.042, 414.655 & 442.210

409-055-0060

Verification

- (1) The Authority shall conduct at least one on-site 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 DMAP per OAR 409-055-0070, Authority staff shall submit the applicable information to DMAP 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 deficiencies are found, the Authority shall take informal or formal enforcement action in compliance with OAR 409-055-0070.
- (10) The Authority may share application information and content submitted by practices and/or verification findings with managed or coordinated care plans, and/or insurance carriers.

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 issue a written warning requiring the practice to submit an improvement plan to the Program within 90 days of the date of the written warning. The improvement plan must include a description of the practice's plan and timeline to correct the deficiency and proposed documentation or other demonstration that would verify the practice is in compliance.
- (2) Authority will review the improvement plan and any documentation the practice submits in accordance with the deficiency, and if remedied, no further action will be taken.
- (3) If a practice fails to submit the improvement plan or move into compliance within 90 days of the date of the written warning, 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 the Authority amends a practice's tier level or revokes PCPCH status this information will be made available to DMAP, the coordinated care or managed care plans, and insurance carriers.

- (5) A practice that has had its PCPCH status revoked may have it reissued after reapplying for recognition and when 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 service documentation required per OAR 410-141-0860, a referral may be made to the DMAP.
- (7) If the Authority finds a lack of documentation per OAR 410-141-0860 to support the authorized tier level, the Authority may make a referral to the DMAP and 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. Recognition Criteria for Patient Centered Primary Care Homes

Table 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #1: Access to Care				
<i>“Health care team, be there when we need you.”</i>				
Standard	Must-Pass ✓	5 points each	10 points each	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. (A)	1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Health-care Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care. (A) ¹	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. (A)
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. (A) ²	N/A	N/A
1.C) Telephone & Electronic Access	1.C.0 PCPCH provides continuous access to clinical advice by telephone. (A)	1.C.1 When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient’s medical record. (A)	N/A	N/A
1.D) Same Day Access	N/A	1.D.1 PCPCH provides same day appointments	N/A	N/A
1.E) Electronic Access	N/A	N/A	N/A	1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request. (A)
1.F) Prescription Refills	N/A	1.F.1 PCPCH tracks the time to completion for prescription refills. (A) ³	N/A	N/A

(A)= Attestation (D) = Data must be submitted

¹ Acceptable CAHPS survey tools include the Health Plan and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.

² Traditional business hours are defined as 8am-5pm

³ Please see technical specifications for more details, but refills are considered complete when they have been signed.

TABLE 1. Recognition Criteria 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	Must-Pass ✓	5 points each	10 points each	15 points each
2.A) Performance & Clinical Quality	2.A.0 PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures. (A) ⁴	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) ⁴	2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (D) ⁴
2.B) Public Reporting	N/A	2.B.1 PCPCH participates in a public reporting program for performance indicators. (A)	2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes . (A)	N/A
2.C) Patient and Family Involvement in Quality Improvement	N/A	2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors at least one quality or safety Initiative per year. (A)	2C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development or educational improvement activities. (A)	2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles. (A)

(A)= Attestation (D) = Data must be submitted

⁴ See Table 2 for the list of PCPCH Quality Measures. Details about the core and menu set, along with technical specifications for all measures are available on the program website.

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #2: Accountability (continued)				
<i>“Take responsibility for making sure we receive the best possible health care.”</i>				
Standard	Must-Pass ✓	5 points each	10 points each	15 points each
2.D) Quality Improvement	N/A	2.D.1: PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience. (A)	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. (A)	2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from 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. (A)
2.E) Ambulatory Sensitive Utilization	N/A	2.E.1 PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population. (A)	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.(A)	2.E.3 PCPCH tracks selected utilization measures and shows improvement or meets a benchmark on selected utilization measures. (A)

(A)= Attestation (D) = Data must be submitted

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #3: Comprehensive Whole Person Care				
<i>“Provide or help us get the health care, information, and services we need.”</i>				
Standard	Must-Pass ✓	5 points each	10 points each	15 points each
3.A) Preventive Services	N/A	3.A.1 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence. (A)	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. (A)	3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services. (A)
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; Patient education and self-management support. (A)	N/A	N/A	N/A
3.C) Mental Health, Substance Abuse, & Developmental Services⁵	3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources. (A)	N/A	3.C.2 PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed. (A)	3.C.3 PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers. (A)

(A)= Attestation (D) = Data must be submitted

⁵ A PCPCH can earn points for both 3.C.2 and 3.C.3 for this standard if applicable (check all that apply).

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #3: Comprehensive Whole Person Care (Continued)				
<i>“Provide or help us get the health care, information, and services we need.”</i>				
Standard	Must-Pass ✓	5 points each	10 points each	15 points each
3.D) Comprehensive Health Assessment & Intervention	N/A	3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors. (A)	N/A	N/A
3.E) Preventive Services Reminders	N/A	3.E.1 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services. (A)	3.E.2 PCPCH tracks the number of unique patients who were sent appropriate reminders. (A)	3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.(A)

(A)= Attestation (D) = Data must be submitted

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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

(A)= Attestation (D) = Data must be submitted

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #4: Continuity (Continued) "Be our partner over time in caring for us."				
Standard	Must-Pass ✓	5 points each	10 points each	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). (A)
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. (A)	N/A	N/A	N/A
4.F) Planning for Continuity	N/A	4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.(A)	N/A	N/A
4.G) Medication Reconciliation	N/A	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 (A).	4.G.2 PCPCH tracks the percentage of patients whose medication regimen is reconciled (A).	4.G.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transitions of care (A).

(A)= Attestation (D) = Data must be submitted

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

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>				
Standard	Must-Pass ✓	5 points each	10 points each	15 points each
5.A) Population Data Management⁶	N/A	5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population, (A) 5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information. (A)	N/A	N/A
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 meet the standards to be “meaningful users” of certified electronic health record technology-established by the Centers for Medicare and Medicaid Services. (A)
5.C) Complex Care Coordination⁷	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. (A)	5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (A)	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. (A)

(A)= Attestation (D) = Data must be submitted

⁶ A PCPCH can earn points for both 5.A.1a and 5.A.b if applicable (check all that apply)

⁷ A PCPCH can earn points for 5.C.1, 5.C.2, and 5.C.3 on this standard if applicable (check all that apply).

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #5: Coordination & Integration (Continued)				
<i>“Help us navigate the health care system to get the care we need in a safe and timely way.”</i>				
Standard	Must-Pass ✓	5 points each	10 points each	15 points each
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. (A)	N/A	N/A
5.E) Referral & Specialty Care Coordination⁸	N/A	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 or caregivers and clinicians.(A)	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). (A)	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. (A)
5.F) End of Life Planning	5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (A)	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 patient opts out). (A)	N/A	N/A

(A)= Attestation (D) = Data must be submitted

⁸ A PCPCH can earn points for 5.E.1, 5.E.2, and 5.E.3 on this standard if applicable (check all that apply).

TABLE 1. Recognition Criteria 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	Must-Pass ✓	5 points each	10 points each	15 points each
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. (A)	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 (A).	N/A	N/A
6.B) Education & Self-Management Support	N/A	6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate (A).	6.B.2 More than 10% of unique patients are provided patient-specific education resources (A).	6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services (A).
6.C) Experience of Care	N/A	6.C.1 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, 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. (A)	6.C.2 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness. (A)	6.C.3 PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness. (A)

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Core Attribute #6: Person- and Family-Centered Care (Continued)				
<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	Must-Pass ✓	5 points each	10 points each	15 points each
6.D) Communication of Rights, Roles, and Responsibilities	N/A	6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, complaint, and grievance procedures; roles and responsibilities ; and has a system to ensure that each patient or family receives this information at the onset of the care relationship. (A)	N/A	N/A

(A)= Attestation (D) = Data must be submitted

Table 2. PCPCH Quality Measures

Table 2. PCPCH Quality Measures

Adult Core Quality Measure Set			
Measure #	Source	Measure	Benchmark
1	National Quality Forum ¹⁰ (NQF) 0421	BMI Screening and Follow-up	47%
2	NQF0028	Tobacco Use: Screening and Cessation Intervention	93%
3	NQF0509	Reminder System for Mammograms	TBD
4	NQF0032	Cervical cancer screening	73%
5	OHA State Performance Measure (NQF 0034)	Colorectal cancer screening	TBD
6	OHA State Performance Measure (NQF 0057)	Comprehensive Diabetes Care: Hemoglobin A1c testing	86%
7	NQF0575	Comprehensive Diabetes Care: HbA1c control	60%
8	OHA State Performance Measure (NQF 0018)	Controlling High Blood Pressure	64%
Pediatric Core Quality Measure Set			
9	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	43%
10	OHA State Performance Measure (NQF0038)	Childhood Immunization Status	82%
11	NQF0036	Use of Appropriate Medications for People with Asthma	91%
12	OHA State Performance Measure (NQF1399)	Developmental screening in the first 3 years of life	50%
13	OHA State Performance Measure (CHIPRA Core Measure #10)	Well child care (0 – 15 months)	77%
14	CHIPRA Core Set Measure #11	Well child care (3 – 6 years)	74%

Table 2. PCPCH Quality Measures

Menu Quality Measure Set			
Measure #	Source	Measure	Benchmark
15	OHA State Performance Measure (CHIPRA Core Measure #12)	Adolescent well-care (12-21 years)	53%
16	OHA State Performance Measure (NQF 0418)	Screening for clinical depression	TBD
17	OHA State Performance Measure (NQF 1517)	Prenatal and Postpartum Care – Prenatal Care Rate	69%
18	OHA State Performance Measure (NQF1517)	Prenatal and Postpartum Care – Postpartum Care Rate	66%
19	OHA State Performance Measure (NQF0002)	Appropriate testing for children with pharyngitis	76%
20	NQF0043	Pneumonia vaccination status for older adults	TBD
21	NQF0044	Pneumonia Vaccination	TBD
22	NQF0041	Influenza Immunization	TBD
23	NQF0066, 67,70, 74	Chronic Stable Coronary Disease	NQF 0070, 83%
24	OHA State Performance Measure	Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse	13%
25	NQF0061	Comprehensive Diabetes Care: Blood Pressure Control	67
26	NQF0064	Comprehensive Diabetes Care: LCL-C Control	40
27	OHA State Performance Measure (NQF0108)	Follow-up care for children prescribed ADHD medication	Initiation: 51% Continuation & Maintenance: 63%
28	OHA State Performance Measure (CHIPRA Core Measure #6)	Adolescent immunizations up to date at 13 years old	70%
29	OHA State Performance Measure (NQF0063)	Comprehensive Diabetes Care: Lipid LDL-C Screening	80%

Table 3. Oregon PCPCH Program and 2008 NCQA Recognition Requirements

Table 3. Oregon PCPCH Program and 2008 NCQA Recognition Requirements
For practices that are recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2008 Level 1 NCQA PCMH Recognition	Attests and provides evidence of recognition to OHA	N/A	N/A
2008 Level 2 NCQA Recognition	N/A	Attests and provides evidence of recognition to OHA	N/A
2008 Level 3 NCQA Recognition	N/A	N/A	Attests and provides evidence of recognition to OHA
PCPCH Performance & Clinical Quality Standard 2.A	2.A.0 PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures	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	2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures
PCPCH Comprehensive Whole Person Care Standard 3.C	Attests to meeting must pass measure 3.C.0	Attests to meeting measure 3.C.2	Attests to meeting measure 3.C.3
PCPCH Coordination and Integration Standard 5.F	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0

Table 4. Oregon PCPCH Program and 2011 NCQA Recognition Requirements

Table 4. Oregon PCPCH Program and 2011 NCQA Recognition Requirements

For practices that are recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2011 Level 1 NCQA PCMH Recognition	Attests and provides evidence of recognition to OHA	N/A	N/A
2011 Level 2 NCQA Recognition	N/A	Attests and provides evidence of recognition to OHA	N/A
2011 Level 3 NCQA Recognition	N/A	N/A	Attests and provides evidence of recognition to OHA
PCPCH Performance & Clinical Quality Standard 2.A	2.A.0 PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures	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	2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures
PCPCH Coordination and Integration Standard 5.F	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0