Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority, Office for Oregon Health Policy and Research	**409**
Agency and Division	Administrative Rules Chapter Number

Zarie Haverkate	**1225 Ferry Street SE, 1st Floor, Salem, OR 97301**	**503-373-1574**
Rules Coordinator	Address	Telephone

RULE CAPTION

Repeal of Temporary Rule and Amendments to Patient-Centered Primary Care Home Program Rules

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

February 19, 2013	10:00 a.m.	1225 Ferry Street SE, 1st floor, Mt. Neahkanie Room, Salem, Oregon	Zarie Haverkate
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

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

AMEND: OAR 409-055--0030, 409-055-0040, & 409-055-0050

REPEAL: OAR 409-055-0030(T)

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stats. Implemented: ORS 413.042, 414.655 & 442.210

RULE SUMMARY

The Oregon Health Authority, Office for Oregon Health Policy and Research is proposing to repeal temporary rule OAR 409-055-0030(T) and make permanent the discretionary 30-day discretionary grace period for PCPHs to submit their annual renewal application and make amendments relating to the annual renewal recognition process and criteria for the Primary Care Home (PCPCH) Program.

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

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

Thursday, February 21, 2013 at 5:00 p.m.

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Zarie Haverkate	Zarie Haverkate, Rules Coordinator	1/8/13
Signature	Printed name	Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Office for Oregon Health Policy and Research — 409

Agency and Division — Administrative Rules Chapter Number

Repeal of Temporary Rule and Amendments to Patient-Centered Primary Care Home Program Rules

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

In the Matter of: **The repeal of OAR 409-055-0030(T) and amendment of OAR 409-055-0030, 409-0040 and 409-0050.**

Statutory Authority: **ORS 413.042, 414.655 & 442.210**

Stats. Implemented: **ORS 413.042, 414.655 & 442.210**

Need for the Rule(s): **The Oregon Health Authority, Office for Oregon Health Policy and Research is proposing to repeal OAR 409-055-0030(T) and make permanent the discretionary 30-day discretionary grace period for PCPHs to submit their annual renewal application and make amendments relating to the annual renewal recognition process and criteria for the Primary Care Home (PCPCH) Program.**

Documents Relied Upon, and where they are available:
The Patient-Centered Primary Care Home Implementation Guide:
http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/index.aspx.

Fiscal and Economic Impact:
No economic impact on individual members of the public is expected.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
None.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:
None. Compliance with the PCPCH Standards is entirely voluntary.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
None. Compliance with the PCPCH Standards is entirely voluntary.

c. Equipment, supplies, labor and increased administration required for compliance:
None. Compliance with the PCPCH Standards is entirely voluntary.

How were small businesses involved in the development of this rule?
The membership of the PCPCH Standard Advisory Committee includes members representing primary care providers from small and rural practices. Public comment was also welcomed at the meetings.

Administrative Rule Advisory Committee consulted? No.
If not, why?: **The PCPCH Standards Advisory Committee served as the Rule Advisory Committee where proposed changes were discussed at several public meetings and public comment was also welcomed. The PCPCH Standards Advisory Committee membership includes primary care providers from small and rural practices.**

Zarie Haverkate — Zarie Haverkate, Rules Coordinator — 1/8/13

Signature — Printed name — Date

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

DIVISION 55
PATIENT-CENTERED PRIMARY CARE HOME PROGRAM

409-055-0030
Practice Application and Recognition Process

(1) Practices, or other entities on behalf of the practice, shall submit a Patient-Centered Primary Care Home Program (PCPCH) Recognition Process Application electronically to the Authority via the Program's online application system found on the Program website. The application shall include data pursuant to ~~per~~ OAR 409-055-0040.

(2) The Authority shall review the application for completed data and compliance with the criteria in OAR 409-055-0040.

(3) When the PCPCH applicant meets the criteria requirements, the Authority shall certify ~~deem~~ the applicant ~~as~~ a Recognized PCPCH Practice and assign a Tier level.

(4) The Authority shall maintain ~~keep~~ instructions and criteria for submitting a PCPCH Recognition Process Application posted on the Program website.

(5) The Authority shall notify p~~P~~ractices ~~shall be notified~~ in writing or electronically of a PCPCHs Tier score or contact~~ed~~ the practice for additional information within 60 days of application submission.

(6) The Authority may deny ~~A practice may be denied~~ PCPCH recognition if it does not meet the criteria in OAR 409-055-0040.

(7) Practices must file a request for review with the Program within 90 days if the practice disagrees with the calculated Tier score.

(8) PCPCHs must renew their recognition annually or at the discretion of the Authority~~OHA~~, but no less than 12 months from the effective recognition date identified to the practice by the Authority. At the Authority's discretion a 30-day grace period may be allowed for PCPCHs to submit their annual renewal application without having a lapse in recognition status. If during the year, a PCPCH believes that it meets the criteria to be recognized at a higher tier, it may request to have its tier status reassessed by re-submitting an application not more than once every six months.

(9) The effective recognition date identified by the Authority shall be the date on which the Authority has completed the application review process.

(10) The Authority may ~~reserves the right to~~ identify a recognition date other than the date of application review process completion if the application is intended to be retroactive.

(11) ~~It is the intent of~~ T~~t~~he Program may ~~to~~ refine the criteria in ~~per~~ OAR 409-055-0040 during the first two years of implementation ~~of the Program~~ based on PCPCH provider and stakeholder feedback. After that ~~this~~ time, the Authority ~~intends to move to a recognition renewal process of once every three years will~~ shall consider revisions to the recognition criteria annually.

(12) Recognition requests must ~~may~~ be sent electronically ~~or by mail to the address posted on the~~ through the Program website.

[Tables: Tables referenced are available from the agency.]

Stat. Auth: ORS 413.042, 414.655 & 442.210
Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0040
Recognition Criteria

(1) The PCPCH measures are divided into "Must-Pass" measures and other measures that place the practice on a scale of maturity or 'tier' that reflect basic to more advanced PCPCH functions.

(2) Must-Pass and Tier 1 measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay.

(3) Tier 2 and Tier 3 measures reflect intermediate and advanced functions.

(4) Except for the 10 Must-Pass measures, each measure is assigned a point value corresponding to the Tier. ~~For a practice to~~ To be recognized as a PCPCH, a practice~~it~~ must meet the following point allocation criteria:

(a) Tier 1: 60~~30~~ – 120~~60~~ points and all 10 Must-Pass Measures

(b) Tier 2: 125~~65~~ – 250~~125~~ points and all 10 Must-Pass Measures

(c) Tier 3: 255~~130~~ points or more and all 10 Must-Pass Measures

(5) A practice's point score shall be calculated through the recognition process pursuant to OAR 409-055-0030.

(6) See Table 1 for a detailed list of Measures and corresponding point assignment.

(7) ~~See Tables 2.A and 2.B for a~~A detailed list of the PCPCH Quality Measures are available on the Program website.

~~(8) Data specifications for the measures listed in Table 2 shall be available on the Program website.~~

(8~~9~~) Quantitative data shall be aggregated at the practice level, not the individual patient level, and there may not be any transfer of any personal health information from the practice to the Authority during the PCPCH application process.

(9~~10~~) The Authority shall develop m~~M~~easure specification, thresholds for demonstrating improvement, and benchmarks for quantitative data elements ~~shall be developed by the Authority~~ and shall make the information ~~made~~ available on the Program website.

(10~~11~~) National Commission for Quality Assurance (NCQA) recognition shall~~will~~ be acknowledged in the Authority's PCPCH recognition process; however, a practice is not required to use its NCQA recognition to meet the Oregon PCPCH standards. A practice that does not wish to use its NCQA recognition to meet the Oregon PCPCH standards must indicate so during the PCPCH application process and submit a complete PCPCH application.

(11~~12~~) Depending on the version of NCQA recognition that was used, practices seeking Oregon PCPCH recognition who~~and~~ wish to use their NCQA PCMH status shall attest to being a NCQA recognized PCMH and submit the following additional information:~~.~~

(a) Table 2 for PCMH practices using 2008 NCQA criteria; or

(b) Table 3 for PCMH practices using 2011 NCQA criteria.

~~(13) Additional required elements for NCQA PCMH recognized practices choosing to use their NCQA status are listed in Table 3 for PCMH practices using 2008 NCQA criteria and Table 1 for PCMH practices using 2011 NCQA criteria.~~

[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) ~~In order~~ T~~t~~o be recognized as a PCPCH, a practice must attest to meeting the standards and submit quantitative data elements as described in Table 1~~ as well as submit quantitative data elements as described in Tables 1 and 2~~.

~~(2) The attestation shall be submitted electronically via the web-based process pursuant to OAR 409-055-0030.~~

~~(3) Recognized PCPCHs shall be scored and assigned a Tier level pursuant to OAR 409-055-0040.~~

(2~~4~~) PCPCHs must submit a~~A~~ttestation data ~~must be submitted by PCPCHs~~ annually as a part of the recognition renewal process.

(3~~5~~) Part of the recognition process shall also include electronic submission of quantitative data about the practice or the practice's patient population.

~~(6) Quantitative data shall be submitted electronically via the web-based reporting process.~~

(4~~7~~) Quantitative data elements ~~selected from Table 2~~ must be submitted by recognized PCPCHs annually for those practices submitting data to meet standard 2.A.2 or 2.A.3.

(5~~8~~) If approved by the practice and the Authority, other entities may submit information on behalf of a practice.

(6~~9~~) Specific data elements required for PCPCH recognition shall be posted on the PCPCH Program website.

(7~~10~~) The Authority, at its~~shall have~~ discretion, may ~~to~~ make exceptions to the reporting requirements for practices collecting data elements ~~outside of those on Table 2~~ for the purpose of quality improvement activities and to any of the reporting requirements.

~~(11) The Authority shall have discretion to make exceptions to any of the reporting requirements referred to in OAR 409-055.~~

(8~~12~~) Practices may request an exception to the reporting requirements on the PCPCH application form. Exceptions are granted due to small practice size and are approved by program staff.

(9~~13~~) The Authority shall notify the practice within 60 days of complete application 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

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Core Attribute #1: Access to Care ***"Health care team, be there when we need you."***				
Standard	**Must-Pass** ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
1.A) In-Person Access	N/A	**1.A.1** PCPCH surveys a sample of its population on satisfaction with in-person access to care. ~~(C)~~[1](A)	**1.A.2** PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools~~.~~[2] ~~(C)~~, reports results, and demonstrates improvement on the access to care domain.[1] (D)	**1.A.3** PCPCH surveys a sample of its population using one of the CAHPS survey tools, reports results on the access to care domain, and meets a benchmark ~~with~~on patient satisfaction ~~in~~with access to care. ~~(C)~~(D)
1.B) After Hours Access	N/A	**1.B.1** PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours. ~~(C)~~~~3~~[2] (A)	N/A	N/A
1.C) ~~Telephone & Electronic~~Same Day Access	~~1.C.0 PCPCH provides continuous access to clinical advice by telephone. (C)~~N/A	N/A1.C.1 PCPCH provides same day appointments.[3] (D)	N/A	N/A

(A)= Contractual attestation (D) = Data must be submitted

[1] ~~(D) = Quantitative data report~~Acceptable CAHPS survey tools include the Health Plans and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.

[2] ~~Acceptable CAHPS survey tools include the Health Plans and Systems, Clinician and Group, and Patient-Centered Medical Home Modules.~~Traditional Business Hours are defined as 8AM-5PM

[3] ~~(C) = Attestation~~To meet the intent of this measure, clinics would reserve some appointments for patients that call that day with urgent needs.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
1.D) Telephone & Electronic Access	**1.D.0** PCPCH provides continuous access to clinical advice by telephone. (A)	**1.D.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.E) Electronic Access	N/A	N/A	N/A	**1.E.3** 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[4] for prescription refills. (A)	N/A	N/A

(A)= Contractual attestation (D) = Data must be submitted

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

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Core Attribute #2: Accountability ***"Take responsibility for making sure we receive the best possible health care."***				
Standard	**Must-Pass** ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
2.A) Performance & Clinical Quality ~~Improvement~~	**2.A.0** PCPCH tracks and reports to the Program one quality metric from core or menu set of PCPCH Quality Measures.[4] ~~(C)~~[5] (D)	~~N/A~~**2.A.1** PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures.[6] (D)	**2.A.2** PCPCH ~~tracks and reports to the OHA~~ demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures.[6] (D)	**2.A.3** PCPCH tracks, reports to the OHA, and ~~demonstrates improvement or~~ meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures.[6] (D)
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 improve-ment purposes . (A)	N/A
2.C) Patient and Family Involvement in Quality Improvement	N/A	**2.C.1** PCPCH involves patients, caregivers, and families as advisors on at least one quality or safety initiative per year. (A)	**2.C.2** PCPCH has estab-lished a formal mechanism to integrate patient, care-giver, and family advisors as key members of quality, safety, program development and/or educational improvement activities.[7] (A)	**2.C.3** Patient, Caregiver, and Family advisors are integrated into the PCPCH and function in peer support or in training roles. (A)

(A)= Contractual attestation (D) = Data must be submitted

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[4] ~~See Table 2 for the list of PCPCH Quality Measures.~~

[5] Details about the core and menu set, along with the technical specifications for all measures, are available on the Program website.

[6] At least one reported measure must be inclusive of children or adolescents if the PCPCH population includes those age groups.

[7] A Patient, Caregiver, and Family Advisory Council that is embedded in the organizational chart and routinely reviews patient experience of care and quality and safety measures for the clinic would satisfy this requirement.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
2.D) Quality Improvement	N/A	**2.D.1**: The PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient Experience. (A)	**2.D.2** The 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 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 selects and reviews utilization measures most relevant to their overall or an at-risk patient population. (A)	**2.E.2** PCPCH sets goals and works to optimize utilization through: monitoring utilization metrics or measures closely linked to utilization on a regular basis, and enacting strategies which are documented to reduce utilization. (A)	**2.E.3** PCPCH shows improvement or meets a benchmark in utilization metrics on measures closely linked to utilization. (D)

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TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Core Attribute #3: Comprehensive Whole Person Care ***"Provide or help us get the health care, information, and services we need."***				
Standard	**Must-Pass** ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
3.A) Preventive Services	N/A	**3.A.1** ~~PCPCH offers or coordinates 90% of recommended preventive services (Grade A or B USPTF and/or Bright Futures periodicity guideline).~~[5] ~~(C)~~PCPCH has assessed current preventive medical care offerings, as compared to a standard (that includes all age and gender appropriate services), and has identified areas for improvement. (A)	~~N/A~~**3.A.2** PCPCH has an improvement strategy in effect to address gaps in preventive medicine offerings as appropriate for the PCPCH patient population. (A)	~~N/A~~**3.A.3** PCPCH ensures the delivery of 90% of all recommended age and gender appropriate preventive services.[8] (A)

(A)= Contractual attestation (D) = Data must be submitted

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[5] ~~The full list of services receiving a United States Preventive Services Task Force (USPSTF) Grade A or B can be found at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The Bright Futures list of recommended services and periodicity can be found at: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.~~

[8] The technical specifications will include the full list of requirements specific to adults, elderly patients, women, children, and adolescents. The full list of services receiving a United States Preventive Services Task Force (USPSTF) Grade A or B can be found at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The Bright Futures list of recommended services and periodicity can be found at: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
3.B) Medical Services	**3.B.0** PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including ~~transitions~~coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support; preventive care; and medication management. ~~(C)~~(A)	N/A	N/A	N/A
3.C) Mental Health, Substance Abuse, & Developmental Services[9]	**3.C.0** PCPCH ~~has a~~documents its screening strategy for mental health, substance use, ~~or~~ and developmental conditions and documents on-site and local referral resources. ~~(C)~~(A)	N/A	**3.C.2** PCPCH ~~directly collaborates or co-manages patients~~ documents a cooperative referral process with specialty mental health, substance abuse, ~~or~~and developmental providers including a mechanism for co-management as needed. ~~(C)~~(A)	**3.C.3** PCPCH ~~is co-located, either actually or virtually with specialty mental health, substance abuse, or developmental providers~~ documents co-location of behavioral health services by providers/behaviorists specially trained in assessing and addressing psychosocial aspects of health conditions. ~~(C)~~(A)

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[9] A PCPCH can earn points for tiers 2 and 3 simultaneously on this measure.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
3.D) Comprehensive Health Assessment & Intervention	N/A	**3.D.1** PCPCH ~~has the ability to conduct~~ documents comprehensive health assessment and interventions~~, when appropriate,~~ for at least three health risk or developmental promotion behaviors.[10] ~~(C)~~(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** The PCPCH tracks the number of unique patients who were sent appropriate reminders. (A)	**3.E.3** More than 20% of all unique patients were sent appropriate reminders. (A)

(A)= Contractual attestation (D) = Data must be submitted

[10] At least one assessment/intervention must be inclusive of children or adolescents if the PCPCH population includes those age groups.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Core Attribute #4: Continuity "Be our partner over time in caring for us."				
Standard	**Must-Pass** ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
4.A) Personal Clinician Assigned	**4.A.0** PCPCH ~~reports~~ meets a benchmark (90%) in the percentage of active patients assigned a personal clinician and/or team. (D)	N/A	N/A	~~**4.A.3** PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team. (D)~~ N/A
4.B) Personal Clinician Continuity	**4.B.0** PCPCH reports the percent of patient visits with assigned clinician and/or team. (D)	N/A	~~N/A~~**4.B.2** PCPCH tracks and improves the percent of patient visits with assigned clinician and/or team. (D)	**4.B.3** PCPCH meets a benchmark in the percent of patient visits with assigned clinician and/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. ~~(C)~~(A)	N/A	N/A	N/A

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TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
4.D) Clinical Information Exchange	N/A	N/A	N/A	**4.D.3** PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). ~~(C)~~(A)
4.E) Planning for Continuity	N/A	**4.E.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.E)~~(4.F) ~~Specialized~~ **Care Setting Transitions**	~~**4.E.0** PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (C)~~N/A	~~N/A~~**4.F.1** PCPCH has a written agreement with its usual hospital providers to ensure that the PCPCH receives admitting and discharge information in a timely fashion, or the PCPCH directly provides routine hospital/urgent care. (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** The PCPCH tracks the percentage of patients whose medication regimen is reconciled (A).	**4.G.3** The PCPCH performs medication reconciliation for more than 50% of transitions of care (A).

(A)= Contractual attestation (D) = Data must be submitted

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Core Attribute #5: Coordination & Integration *"Help us navigate the health care system to get the care we need in a safe and timely way."*				
Standard	**Must-Pass** ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
5.A) Population Data Management	N/A	**5.A.1~~a~~** PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population, including the identification of sub-populations. ~~[6]~~[11] ~~(C)~~(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. (C)[7]~~	~~N/A~~**5.A.2** PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior. [12] (A)	N/A

(A)= Contractual attestation (D) = Data must be submitted

~~[6]~~ [11] This could be achieved through use of a panel management system and/or registry.

~~7 PCHs may choose to create lists or registries of sub-populations based on a variety of conditions (e.g., diabetes or pregnancy) or demographic characteristics (e.g. children < age 1 or women). Proactive management could be demonstrated through the use of a list or registry to track and improve care delivery through strategies such as care protocols and patient or clinician reminders.~~

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

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
5.B) Electronic Health Record	N/A	N/A	N/A	**5.B.3** PCPCH has an ~~certified~~electronic health record and the PCPCH practitioners must be ~~demonstrates~~"meaningful users" of the ~~certified~~ electronic ~~health~~ record, according to the Centers for Medicare and Medicaid Services rules. ~~(C)~~(A)
5.C) Complex Care Coordination[13]	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.~~PCPCH attests to a process for identifying patients with complex care needs and enrolling them in services for care coordination (A).	**5.C.2** ~~PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.~~PCPCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions (A).	~~N/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)= Contractual attestation (D) = Data must be submitted

[13] A PCPCH can earn points for tiers 1, 2, and 3 simultaneously on this measure.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
5.D) Test & Result Tracking	N/A	**5.D.1** PCPCH ~~demonstrates tracking of~~ tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians. ~~(C)~~(A)	N/A	N/A
5.E) Referral & Specialty Care Coordination[14]	N/A	**5.E.1~~a~~** 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. ~~(C)~~(A) ~~**5.E.1b** PCPCH either manages hospital or skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings. (C)~~	~~N/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, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians, and coordinates care where appropriate for community settings outside the PCPCH.~~ ~~Coordination must include hospital or skilled nursing facility care as well as other community settings~~ demonstrates cooperation with community service providers, including referrals outside the PCPCH such as dental, educational, social service, foster care, public health~~, or long term care settings~~ and pharmacy services. ~~(C)~~(A)

(A)= Contractual attestation (D) = Data must be submitted

[14] A PCPCH can earn points for tiers 1, 2, and 3 simultaneously on this measure.

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
	~~N/A~~	~~N/A~~	~~**5.F.2** PCPCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan that includes the following: self management goals; goals of preventive and chronic illness care; action plan for exacerbations of chronic illness (when appropriate); end of life care plans (when appropriate). (C)~~	~~N/A~~
~~**5.G.0**~~**5.F.O** PCPCH demonstrates a process to offer~~s~~ or coordinate~~s~~ hospice and palliative care and counseling for patients and families who may benefit from these services. ~~(C)~~(A)	N/A	N/A	N/A
~~**5.G.**~~**5.F) End of Life Planning**				

(A)= Contractual attestation (D) = Data must be submitted

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Core Attribute #6: Person- and Family-Centered Care ***"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."***				
Standard	**Must-Pass** ✓	**Tier 1** **5 points each**	**Tier 2** **10 points each**	**Tier 3** **15 points each**
6A) Language / Cultural Interpretation	**6.A.0** PCPCH documents the offer~~s~~ and/or use~~s~~ of either providers who speak a patient and family's language or time of service in-person or telephonic trained interpreters to communi-cate with patients and families in their language of choice. ~~(C)~~(A)	N/A	~~N/A~~**6.A.2** PCPCH translates written patient materials into all languages spoken by more than 30 households in the PCPCH (A).	N/A
6B) Communication of Rights, Roles, and Responsibilities	N/A	**6.B.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. (A)	N/A	N/A

(A)= Contractual attestation (D) = Data must be submitted

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
~~6B)~~6C) **Education & Self-Management Support**	N/A	~~**6.B.1** PCPCH provides patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. (C)~~ **6.C.1** PCPCH completes one educational service (providing educational information about diagnosis, prognosis and treatment of conditions; education to promote health behaviors change; education and anticipatory guidance on normal childhood development) for 10% of clinic population. (A)	~~N/A~~**6.C.2** PCPCH completes one educational service (as in tier 1) and one self-management service (providing education or referral to educational programs to promote self-management of chronic conditions; providing patients with tools to support self management of chronic conditions; referring patients to resources for further education and support) for 10% of clinic population (A).	~~N/A~~**6.C.3** PCPCH completes one educational service (as in tier 1) and one self-management service (as in tier 2) AND assesses patient activation for 10% of clinic population (A).

(A)= Contractual attestation (D) = Data must be submitted

TABLE 1. ~~Initial Implementation Measures for Patient Centered Primary Care Homes~~Measures for Patient Centered Primary Care Homes

Standard	Must-Pass ✓	Tier 1 5 points each	Tier 2 10 points each	Tier 3 15 points each
~~6C~~ 6D) **Experience of Care**	~~N/A~~**6.D.0** PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on provider or health team communication, coordination of care, helpfulness of office staff, and overall provider or health team rating. (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. (C)~~N/A	~~**6.C.2**~~**6.D.2** PCPCH surveys a sample of its population at least annually, on their experience of care using one of the CAHPS survey tools. ~~(C)~~The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness. (A)	~~**6.C.3**~~**6.D.3** PCPCH surveys a sample of its population 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. ~~(C)~~(D)

(A)= Contractual attestation (D) = Data must be submitted

~~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[8] Number~~
~~Adult Weight Screening and Follow-up~~	~~X~~			~~NQF0421~~
~~Medical Assistance With Smoking and Tobacco Use Cessation~~	~~X~~			~~NQF0028~~
~~Breast cancer screening~~	~~X~~			~~NQF0031~~
~~Cervical cancer screening~~	~~X~~			~~NQF0032~~
~~Colorectal cancer screening~~	~~X~~			~~NQF0034~~
~~Hemoglobin A1c testing~~	~~X~~			~~NQF0057~~
~~Comprehensive Diabetes Care: HbA1c control~~	~~X~~			~~NQF0575~~
~~Controlling High Blood Pressure~~	~~X~~			~~NQF0018~~
~~Body Mass Index (BMI) Percentile~~		~~X~~		~~NQF0024~~
~~Asthma Assessment~~		~~X~~		~~NQF0001~~
~~Developmental screening < 3 years old~~		~~X~~		~~N/A~~
~~Well child care (0 – 15 months)~~		~~X~~		~~N/A (CHIPRA Core Set Measure #10)~~
~~Well child care (3 – 6 years)~~		~~X~~		~~N/A (CHIPRA Core Set Measure #11)~~

~~[8] The National Quality Forum (NQF) is a nonprofit organization that operates to improve the quality of American healthcare. Consensus standards endorsed by NQF are used for measuring and publicly reporting on the performance of different aspects of the healthcare system, and are widely viewed as the "gold standards" for the measurement of healthcare quality.~~

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

~~Measure Title~~	~~Adult Core Set~~	~~Pediatric Core Set~~	~~Menu Set~~	~~National Quality ForumNumber~~
~~Adolescent well-care (12-21 years)~~		~~X~~		~~N/A (CHIPRA Core Set Measure #12)~~
~~Childhood Immunization Status~~		~~X~~		~~NQF0038~~
~~Use of Appropriate Medications for People with Asthma~~				~~NQF0036~~
~~Screening for clinical depression and follow-up plan~~			~~X~~	~~NQF0418~~
~~Frequency of ongoing prenatal care~~			~~X~~	~~N/A (CHIPRA Core Set Measure #2)~~
~~Appropriate testing for children with pharyngitis~~			~~X~~	~~NQF0002~~
~~Pneumococcal immunization (65+)~~			~~X~~	~~NQF0043, NQF0044~~
~~Influenza immunization (50+)~~			~~X~~	~~NQF0039, NQF0041~~
~~Coronary Artery Disease (CAD) Composite~~			~~X~~	~~NQFs 0066, 67, 70, 74~~
~~Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse~~			~~X~~	~~N/A (RAND)~~
~~Blood pressure control for patients 18-75 years with diabetes~~			~~X~~	~~NQF0061~~
~~LDL-C control for patients 18-75 years with diabetes~~			~~X~~	~~NQF0064~~
~~Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)~~			~~X~~	~~NQF0108~~

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

~~**Measure Title**~~	~~**Adult Core Set**~~	~~**Pediatric Core Set**~~	~~**Menu Set**~~	~~**National Quality Forum Number**~~
~~**Adolescent immunizations up to date at 13 years old**~~			~~X~~	~~N/A (CHIPRA Core Set Measure #6)~~
~~**Blood Pressure Measurement**~~			~~X~~	~~NQF0013~~
~~**Diabetes: Lipid profile**~~			~~X~~	~~NQF0063~~

~~**Table 2.B. Additional PCPCH Qualitative Measures**~~

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

~~Table 3. Oregon PCPCH Program 2008 NCQA Recognition Requirements~~

Table ~~3~~2. Oregon PCPCH Program 2008 NCQA Recognition Requirements

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	**Tier 2**	**Tier 3**
2008 Level 1 NCQA PCMH Recognition	Contractually a~~A~~ttests to recognition	N/A	N/A
2008 Level 2 NCQA Recognition	N/A	Contractually a~~A~~ttests to meeting must pass measure	N/A
2008 Level 3 NCQA Recognition	N/A	N/A	Contractually a~~A~~ttests to meeting must pass measure
OR Accountability Measure ~~2.A~~	Tracks and reports two measures from core set and one measure from the menu set of PCPCH Quality Measures~~ Attests to tracking one measure from the core and/or menu set of measures in Table 2.A~~	Demonstrates improvement on~~Reports~~ two measures from the core set and/or one from the menu set of PCPCH Quality Measures~~measures in Table 2.A~~	Tracks, r~~R~~eports and meets benchmarks on two measures from the core set and one from the menu set of PCPCH Quality Measures~~measures in Table 2.A~~
OR Comprehensive Whole Person Care Measure 3.C~~A~~	Contractually a~~A~~ttests to meeting must pass measure	Contractually a~~A~~ttests to meeting must pass measure	Contractually a~~A~~ttests to meeting must pass measure
OR Coordination and Integration 5. F~~G~~	Contractually a~~A~~ttests to meeting must pass measure	Contractually a~~A~~ttests to meeting must pass measure	Contractually a~~A~~ttests to meeting must pass measure

~~Table 4. Oregon PCPCH Program 2011 NCQA Recognition Requirements~~

Table ~~4~~3. Oregon PCPCH Program 2011 NCQA Recognition Requirements

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2011 Level 1 NCQA PCMH Recognition	Contractually a~~A~~ttests to meeting must pass measure	N/A	N/A
2011 Level 2 NCQA Recognition	N/A	Contractually a~~A~~ttests to meeting must pass measure	N/A
2011 Level 3 NCQA Recognition	N/A	N/A	Contractually a~~A~~ttests to meeting must pass measure
OR Accountability Measure ~~2.A~~	Contractually a~~A~~ttests to tracking one measure from the core and/or menu set of measures ~~in Table 2.A~~	Reports two measures from the core set and one from the menu set of measures ~~in Table 2.A~~	Reports and meets benchmarks on two measures from the core set and one from the menu set of measures ~~in Table 2.A~~
OR Coordination and Integration 5.F~~G~~	Contractually a~~A~~ttests to meeting must pass measure	Contractually a~~A~~ttests to meeting must pass measure	Contractually a~~A~~ttests to meeting must pass measure