Patient-Centered Primary Care Home Standards Advisory Committee 2015 Report

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Executive Summary

The Patient-Centered Primary Care Home (PCPCH) Program was created by the Oregon Legislature through passage of House Bill (HB) 2009 as part of a comprehensive statewide strategy for health system transformation. The program is part of Oregon's vision for better health, better care and lower costs for all Oregonians. The PCPCH is Oregon's version of the "medical home" which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Following the passage of HB 2009, the Oregon Health Authority (OHA) convened a Standards Advisory Committee (committee) of Oregon stakeholders including patients, clinicians, health plans and payers to assist the OHA in developing the PCPCH model of care. The committee developed six core attributes and a number of standards that describe the care delivered by PCPCHs. The core attributes, standards and measures are intended as a tool for OHA, policymakers and other Oregon stakeholders seeking a common framework to assess the degree to which primary care clinics are functioning as primary care homes and promote widespread adoption of the model. The OHA reconvened the committee in 2010 and 2012 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation.

The committee reconvened again from June to December 2015 and was tasked with the following objectives:

1. Revise a specific set of existing standards and measures based upon staff and community experience with the model;
2. Refine the current tier structure/measurement system; and
3. Develop recommendations on standards for integration of primary physical health care in sites where the main focus is delivery of behavioral health care services.

Among the proposed changes presented in this report include clarifying and strengthening existing standards and measures, the addition of one new "must pass" measure, and a redistribution of total available points across five tiers. The proposed changes are designed to incrementally adapt the model to the changing health care needs of the state, align the model with the best evidence where it is available, and also to improve the effectiveness of the standards and measures overall.

Stakeholders across Oregon have identified the need to provide more integrated physical and behavioral health care services. The Oregon Legislature signaled the state's commitment to improved integration through the enactment of Senate Bill 832 which directed OHA to develop standards for "achieving integration of behavioral health services and physical health services in Patient-Centered Primary Care Homes and Behavioral Health Homes." OHA relied upon the expertise of this committee to advise us with the development of integration standards. This report includes a conceptual framework to guide integration standards and a proposed Behavioral Health Home model.

The committee also re-examined the guiding principles proposed by the initial Standards Advisory Committee in 2009. These guiding principles are divided into five categories: strategies for payment reform, incentives for delivery system change, strategies for measurement, encouraging continuous improvement and aligning incentives across the health care system. The 2015 committee noted the importance of the strategies for payment reform principles for advancing health system transformation in Oregon.

Introduction

Background

The Oregon Health Fund Board (HFB) was formed in 2007 at the direction of the Oregon Legislature to develop a comprehensive plan for reforming Oregon's health care system. The Health Fund Board identified stimulating innovation and improvement within the health care delivery system as a key building block to achieving the "Triple Aim" of health care reform: a healthy population, extraordinary patient care for everyone, and reasonable costs shared equitably. [1] The HFB identified the development of primary care medical homes as a central strategy for improving the health care delivery system.

The conceptual work of the HFB on primary care homes was incorporated into two pieces of legislation enacted during the 2009 legislative session. House Bill (HB) 2009 created the Oregon Health Authority (OHA), established the Oregon Health Policy Board, and established a Patient-Centered Primary Care (PCPCH) Home program within the Office for Oregon Health Policy and Research (OHPR).

To assist OHPR in developing strategies to identify and measure primary care homes, the OHA Director appointed a 15 member Patient-Centered Primary Care Home Standards Advisory Committee (committee) made up of diverse Oregon stakeholders including patients, clinicians, health plans and purchasers. The committee was tasked with the following:

- Define of core attributes of the PCPCH to promote a reasonable level of consistency of services provided by patient-centered primary care homes
- Develop a process to identify PCPCH's that meet the core attributes defined by OHA
- Define uniform quality measures for PCPCH's that build from nationally accepted measures and allow for standard measurement of PCPCH performance
- Define uniform quality measures for acute care hospital and ambulatory services that align with the PCPCH quality measures.
- Create policies that encourage the retention of, and the growth in, the numbers of primary care providers.

Over the course of seven meetings between October 2009 and January 2010 the committee developed six core attributes and a number of standards that describe the care delivered by PCPCHs. The six core attributes are Accessibility to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration, and Person and Family Centered Care. Using the framework of the core attributes and standards, the committee also developed a set of detailed PCPCH measures. The committee articulated its core attributes and standards in patient-centered language in order to help communicate the benefits of this new model of care to the general public.

[1] Oregon Health Fund Board. (2008). Delivery Systems Committee Recommendations; Report to the Oregon Health Fund Board.

The PCPCH model framework is intended as a tool for OHA, policymakers and other Oregon stakeholders to assess the degree to which primary care clinics are functioning as patient-centered primary care homes and promote widespread adoption of the model. Cognizant of the evolving evidence base that supports the effectiveness of the medical home model and the need to continuously improve and adapt the model to the health care needs of Oregonians, OHA reconvened the committee in 2010 to discuss pediatric aspects of care, [2] and in 2012 to refine the PCPCH model. [3]

PCPCHs are an important part of healthcare transformation in Oregon, and are a foundational component of the Coordinated Care Model (CCM) Oregon has adopted through Coordinated Care Organizations (CCOs) as the basis for transformation. CCOs are community-based organizations that include all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). As a component of this model, CCOs are required to use recognized PCPCHs for primary care delivery to the greatest extent possible in their networks. Approximately 80% of CCO members receive their primary care through a recognized PCPCH. [4]

Report Overview

This report contains proposed revisions to PCPCH model standards and measures recommended by the 2015 standards advisory committee which was convened by OHA to assist with model refinement process as the state proceeds with health care delivery system transformation. Also included in this report are proposed Behavioral Health Home (BHH) standards to further support physical and behavioral health care integration and strengthen Oregon's behavioral health care delivery system.

The recommendations and strategies contained in this report will inform the PCPCH Program, OHA, the delivery system, and other stakeholders while aligning with state priorities and national efforts to transform primary care.

[2] Oregon Health Authority (2010). *Standards and Measures for Patient Centered Primary Care Homes*. Retrieved from http://www.oregon.gov/oha/pcpch/SACdocs/2010%20Standards%20Advisory%20Committee%20Report.pdf
[3] Oregon Health Authority. (2013). *Standards and Measures for Patient Centered Primary Care Homes*: Final Report of the Patient-Centered Primary Care Home Standards Advisory Committee October 2012. Retrieved from http://www.oregon.gov/oha/pcpch/SACdocs/2012%20Standards%20Advisory%20Committee%20Report.pdf
[4] Oregon Health Authority. (2014). *Patient-centered primary care home enrollment*. Retrieved from http://www.oregon.gov/oha/Metrics/Pages/measure-patient-centered.aspx

PCPCH Standards Advisory Committee 2015

Scope of Work

The 2015 Patient-Centered Primary Care Home Standards Advisory Committee (the committee) was convened to provide OHA with policy and technical expertise in the next phase of implementation of the PCPCH model. The Oregon Legislature signaled the state's commitment to continued improvement through the enactment of Senate Bill 832 which directed OHA to develop standards for "achieving integration of behavioral health services and physical health services in Patient-Centered Primary Care Homes and Behavioral Health Homes."

The committee was tasked by OHA with three goals:

1. Revise a specific set of existing standards and measures based upon staff and community experience with the model;
2. Refine the current tier structure/measurement system; and
3. Develop recommendations on standards for integration of primary physical health care in sites where the main focus is delivery of behavioral health care services.

Key Guidelines and Considerations

In addition to the specific language in HB 2009, the committee was required to frame its work based on the following guidelines and considerations:

- The committee should incorporate new evidence, where possible, into the model;
- The rigor of the model should increase so that practices are incentivized to continue along in the transformation process for those that have already achieved a tier 3 status while continuing to support practices currently achieving a tier 1 status;
- The committee should focus on standards and measures only, recognizing that technical specifications consistent with the recommendations of the committee will be developed at a later time;
- The model should minimize the burden of reporting wherever possible, while recognizing that measuring data in a standardized away allows for the model to be replicated and confirmed;
- Standards and measures developed by the committee should be sufficiently broad to be applicable to primary care clinics of different sizes, with different patient populations and in different geographic regions across Oregon;
- Standards and measures should build on existing the PCPCH model, health system transformation, and quality measurement work in Oregon and seek to be broadly acceptable to all major stakeholders; and
- While the committee will not consider payment reform specifically, standards should be developed with the goal of being used by public and private payers seeking to implement primary care payment reform to support the PCPCH model.

Committee Selection

The PCPCH Standards Advisory Committee applicants were drawn from past committee rosters, an open call for nominations, and contacts made to stakeholders such as providers, content experts and patients. The 2015 committee members were appointed by the OHA Director. Since this committee was tasked with developing behavioral and physical health integration standards, there was significant representation from behavioral and mental health stakeholders (see Appendix A for a committee roster). The committee met ten times from June 2015 until December 2015 in both Portland and Salem. The committee discussed PCPCH model refinement for the first four meetings, and integration of physical health care in sites where the main focus is delivery of behavioral health care services at the remaining meetings.

The 2015 committee served as a Rules Advisory Committee (RAC). The revised standards and measures will be submitted as Oregon Administrative Rules (OARs), and will be available for further public comment after submission.

Selected committee members and content experts will comprise a Technical Assistance Group (TAG) to assist program staff with updating the accompanying PCPCH Technical Assistance and Reporting Guidelines for the revised standards and measures.

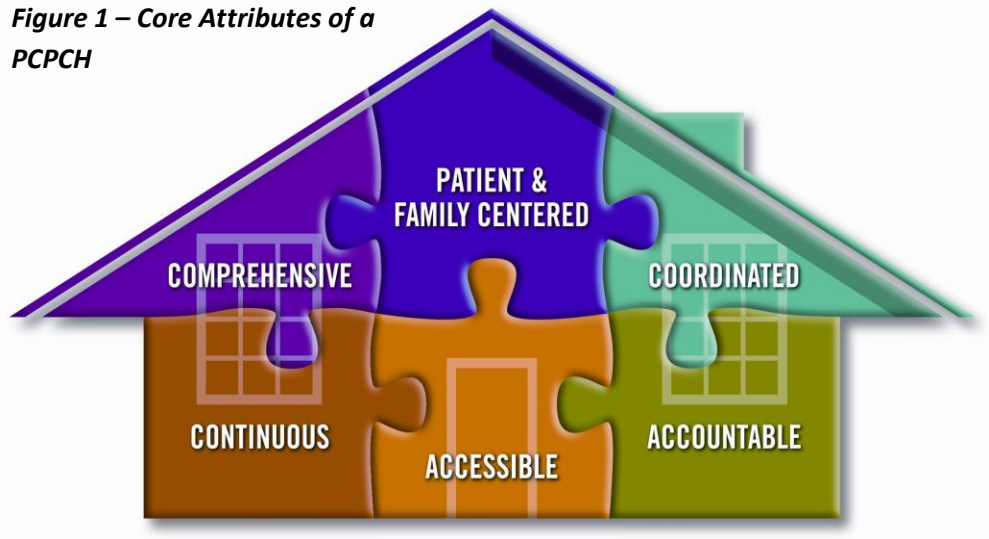
Patient-Centered Primary Care Home (PCPCH) Model

Background, Evidence and Sources

The Oregon Legislature adopted the PCPCH model which is a variant of the medical home concept to help strengthen primary care delivery and improve the state's Triple Aim outcomes. While the evidence suggests that medical homes can improve the structure, processes and outcomes of care, the evidence is still evolving. [5] [6] [7] OHA therefore decided to implement the PCPCH model incrementally to obtain provider buy-in, allow for capacity building, improve the model's effectiveness, and continually adapt the model to the state's changing health care needs. OHA also communicated its intention to reconvene the committee annually to further refine the model. At the time of this report, 600 clinics across the state have been recognized as a Patient-Centered Primary Care Home.

The PCPCH model of care delivery is based on six core attributes (see figure 1), and numerous standards and measures. The core attributes and standards of the PCPCH model build on the conceptual work of the HFB, the Oregon Legislature as well as other national and state efforts to describe the primary care home model. They are also intended to establish a common framework for understanding the structure and functions of a primary care home from the perspectives of patients and families. The core attributes help to define the specific measures within each standard and also guide practices on their transformational path. The measures are intended as a functional tool that can be used to recognize clinics currently delivering primary care home functions and support payment reform or other incentives that will drive an increasing number of clinics towards functioning as advanced primary care homes.

Figure 1 – Core Attributes of a PCPCH



[5] Enthovan, C.A., Crosson, F.J & Shortell, S.M. (2007) Redefining Health Care: Medical Homes or Archipelagoes to Navigate? *Health Affairs*, 26(5) 1366- 1372

[6] Stange, K.C., Nutting, P.A., & Miller, W.L. (2010) Defining and Measuring the Patient-Centered Medical Home, *Journal of General Internal Medicine*, 2596), 601-612.

[7] Medicare Payment Advisory Commission (MEdpAC) (2008) Report to Congress: Reforming the Delivery System, June, 2008, retrieved from: (http://www.medpac.gov/documents/june08_EntireReport.pdf) on August 8, 2012.

In preparation for the 2015 committee meetings, the PCPCH Program staff drafted proposed revisions to the 2014 PCPCH model standards and measures for the committee's consideration. A literature review was undertaken to provide an evidence base for the proposed revisions. Among the other inputs for the proposed revisions included a review of primary care home policy in the state and around the country, NCQA, NQF and other state's medical home standards and measures, feedback from stakeholders, providers, and clinics in the state, and information gathered by program staff during PCPCH site visits. [8] A 2014 qualitative analysis of site visit reports[9], an examination of PCPCH cost and utilization [10] and program implementation evaluation [11] further guided proposed revisions.

Standards and Measures

Using the PCPCH model core attributes as a framework, the committee evaluated the proposed revisions to the standards and measures and provided recommendations to OHA on adoption of these revisions. This section of the report includes a brief summary the key committee discussion points for the proposed revisions and the rationale and evidence for the final committee recommendations. Please refer to Appendix B for a comprehensive table of the recommended revisions to the PCPCH model standards and measures. If all the proposed changes are adopted the total available points in the revised PCPCH model will increase from 380 to 390 and there will 11 "must pass" measures instead of 10.

Measure 1.C.1 Access to clinical advice outside of in-person office visits is an important primary care home function associated with decreased emergency and urgent care utilization. [12] [13]All PCPCHs must attest to *Measure 1.C.0 - PCPCH provides continuous access to clinical advice by telephone.* Therefore, the committee recommended eliminating *Measure 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* since demonstrating this measure is a significant part of how 1.C.0 is verified at site visits. It is also recommended that language be added in the technical assistance guide specifying after-hours access must be documented in the medical record. The language should align with NCQA-PCMH: "documenting clinical advice in the medical record" and "documenting after-hours clinical advice in the patient records."

Measure 1.E.3 The Meaningful Use (MU) measures were included in the PCPCH model in order to foster policy and practice alignment. In the current model, over 80% of PCPCHs attest to *Measure 1E.3 - Using a method that satisfies either Stage 1 or Stage 2 meaningful use*

[8] By the end of 2014, approximately 15% of recognized PCPCHs had a site visit at their clinic.
[9] Center for Outcomes Research and Education, Providence Health & Services. (2014). Oregon's Patient-Centered Primary Care Home Program Common Standards and Best Practices: Results from a 2013 Narrative Evaluation. Submitted to Oregon Health Authority.
[10] Wallace, N. (2014). Patient Centered Primary Care Home (PCPCH) Evaluation: Cost and Efficiency. Portland State University. Submitted to the Oregon Health Authority.
[11] Rissi, J.J. & Baker, R. (2014). Report on the Results of the 2012-2013 Qualitative Patient-Centered Primary Care Home Evaluation. Portland State University. Submitted to the Oregon Health Authority.
[12] Takach, M (2011) Reinventing Medicaid: State Innovations to qualify and pay for Patient Centered Medical Homes show promising results. Health Affairs, 30(7), 1325-1334.
[13] Solberg, L. (2011) Advanced Access--Fad or Important? Comment on" Advanced Access Scheduling Outcomes". Archives of Internal Medicine, 171(17).

measures, the PCPCH provides patients with an electronic copy of their health information upon request. However, PCPCH site visit results indicate that there is significant variability in how MU measures are achieved, and often the processes in place to meet the MU measures are not always transformative. The committee felt the MU measures were weighted too heavily in the model, and recommended reducing the points to 5 from 15 for this measure.

Standard 1.F Medication management is a significant aspect of a robust PCPCH. The committee noted timely medication refills are important from the patient's perspective, and evidence demonstrates timely prescription refills are crucial to patient adherence to prescribed medical regimens and control of chronic conditions.[14] Therefore the committee recommended *Standard 1.F – Prescription Refills* be weighted more heavily in the PCPCH model. Different levels of accomplishment and a benchmark or quality improvement process were also recommended as the measure in its current form does not encourage transformation. There is no known national benchmark for prescription refills and this standard would need further refinement in the technical specifications.

Standard 2.A Measuring and improving on clinical quality is a foundational element of primary care homes and strong evidence supports the effectiveness of quality improvement.[15] [16]*Standard 2.A. requires PCPCHs to report and track clinical quality measures.* The intent of these measures is to demonstrate that primary care homes have the capacity to monitor clinical quality data and improve their performance where appropriate. Application data submission and site visit experience have demonstrated significant variability in the ability of PCPCHs to reliably access and utilize data for quality improvement work. The committee recommended additional tiers should be added to promote a focus on improvement.

Measure 3.A.1 Preventive care is a core component of primary health care. To meet *Measure 3.A.1 a PCPCH must routinely offer or coordinate recommended age and gender appropriate preventive services based on best available evidence.* During PCPCH site visits program staff have observed tremendous variation in the scope of preventive care services offered or coordinated. Therefore, the committee recommended adding the following language to the measure: "and the clinic identifies areas for improvement." This change will require PCPCHs to demonstrate they have reviewed evidence-based recommendation guidelines and are knowledgeable about where they need to work to close gaps. The committee also recommended modifying the language in the measure to "appropriate for your clinic population (i.e. age and gender)" so the measure can be more broadly applied.

While discussing measure 3.A.1., the committee noted there should be greater emphasis on preventive care in the model, and the measure should be more directive in what is required in preventive services. The committee recommended adding "preventive services" to *Measure*

[14] Odegard, P. S., & Gray, S. L. (2008). Barriers to medication adherence in poorly controlled diabetes mellitus. The Diabetes Educator, 34(4), 692-697.
[15] Berwick, D. M., Nolan, T.W., and Whittington, J. (2008) The Triple Aim: Care, Health and Cost.
Health Affairs, 27(3)
[16] Bernstein, J., Chollet, D., & Peikes, D (2010) Medical Homes: Will they improve primary care? Mathematica Policy Research, Inc. Retrieved from http:www.mathematicampr.com/health/series.asp

3.B.0 – Medical Services (must pass), and include specifications in the Technical Assistance Guide that align with NCQA-PCMH standards.

Standard 3.C Assessment and appropriate intervention for mental health, substance use and developmental, behavioral or social delays is a core component of primary health care. The evidence is clear that coordination and integration of care for individuals with mental health, substance use, or developmental conditions is strongly associated with improved health outcomes in these populations.[17] [18] The intent of Standard 3.C is to ensure that primary care homes are routinely assessing their patients for these conditions and providing appropriate treatment, referral and care coordination when needed.

During PCPCH site visits program staff have observed significant differences in the robustness of screening and intervention strategies. In particular the meaning of cooperative referral process and co-management has shown enormous variability. Closing the chasm between traditional medical and behavioral health services is an area of emphasis across Oregon. It is clear that co-location of these services, while potentially and actually beneficial, does not offer the same patient benefits as integration of services. Evidence demonstrating the patient and clinic staff benefits of integration with behavioral health professionals is particularly strong. [19]

To address this variation and provide a clearer framework defining physical and behavioral health integration as directed by Senate Bill 832, the committee recommended significant revisions to Standard 3.C. In measure 3.C.0 PCPCHs will be required to screen for mental health, substance abuse and development conditions. In the current model, the "and" is an "or". This change will improve consistency in how the measure is implemented by clinics and improve the services provided. In the current model, co-location is the 3.C.3 measure and there is no differentiation for integration. The committee acknowledged many differences between co-location and integration of behavioral health services in a PCPCH. Therefore, co-location was added as an option for the 3.C.2 measure and a new 3.C.3 measure for integration was created.

Prior to this recommendation, the committee discussed general challenges posed in Standard 3.C. such as defining integration, the differentiation between behavioral health services and specialty mental health, and health system administrative processes that do not support physical and behavioral health care integration. The committee recommended the technical specifications for this standard clearly describe the difference between co-location and integration, and include a list of definitions from the Agency for Healthcare Research and Quality (AHRQ) to further guide interpretation of each measure.

Standard 3.E As with the other Meaningful Use (MU) aligned measures under consideration in the PCPCH model, the committee noted that Standard 3.E. may align with state and federal policy, but does not necessarily encourage transformation. The committee recommended reordering the Measures in *Standard 3.E – Preventive Services Reminders* so there is less

[17] National Institute of Mental Health (NIMH) (2008) The Numbers Count: Mental Disorders in America, Bethesda, MD: National Institute of Mental Health, retrieved from http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-inamerica
[18] Robinson, P & Reiter, J. (2007) Behavioral Consultation and Primary Care: A guide to Integrating Services, New York: Springer.
[19] Collins, Hewson, Munger, & Wade. (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund. http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

emphasis on aligning with MU. It was recommended Measure 3.E.3 require PCPCHs to track the completion of recommended preventive services to improve accountability, patient-centeredness and coordination.

Standard 4.G The inclusion of medication reconciliation and management in the PCPCH model is based on evidence that significant health problems are caused in part by medication errors. [20] As with the other PCPCH model measures aligned with Meaningful Use (MU), the committee felt that *Standard 4.G - Medication Reconciliation* has too great an emphasis in the current model. Therefore, they recommended the measures in the standard be reordered and renamed *Standard 4.G. - Medication Reconciliation and Management.* The committee recommended PCPCHs be required to report and track the percentage of patients whose medication regimen is reconciled for Measure 4.G.2, and be required to provide Comprehensive Medication Management for appropriate patients and families to meet Measure 4.G.3. Comprehensive Medication Management will be defined in the technical specifications for the measure. Incorporating the concepts of Comprehensive Medication Management aligns with the premise that 15 point measures in the PCPCH model are intended to be truly transformational.

Standard 5.A To effectively coordinate and manage care a primary care home should be able to produce and track basic information about its patient population. In addition, clinics should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease or health care need. The committee recommended combining Measures 5.A.1.a and 5.A.1.b into one, and adding *"and utilize"* so *the Measure 5.A.1 will read 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,* thus encouraging clinics to act on data just not produce it. The committee also recommended adding a medium value measure focused on risk stratification and management. It was noted a high value measure should be considered for future model refinement.

Measure 5.C.1 The committee recommended the language for this measure be revised to read *Measure 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.* This language recognizes the roles of different members of the health care team in different PCPCHs, and focus on function rather than process.

Some committee members noted care coordination should be more clearly defined and specifically address the coordination of high risk patients. Care coordination has been recognized by past advisory committees as an important component the PCPCH model, and has been incorporated into several other PCPCH measures which are broad enough to encompass specific high risk populations. It is the sum of these measures that fully capture care coordination in the PCPCH model.

[20] Barker, Flynn, Pepper, Bates, & Mikeal. (2002). Medication errors observed in 36 health care facilities. Archives of Internal Medicine, 162(16), p.1897-1903

Standard 6.C Patient-Centered Primary Care Homes should understand the care experiences of its patients and their family members and seek to improve the care experience where appropriate. Patient surveys can be an effective method to gather feedback from patients and identify areas for improvement. In the current PCPCH model clinics are not required to survey patients, so the committee recommended changing Measure 6.C.1 to a Must Pass requirement stating: *Measure 6.C.0 -PCPCH surveys a sample of its patients and families at least every two years on their experience of care*. While the use of CAHPS is strongly encouraged, it was not recommended as a requirement to meet Measure 6.C.1. The committee also recommended the other measures in the standard be revised to include the language "demonstrates the utilization of survey data in quality improvement process" to encourage clinics to utilize the patient survey data in a meaningful way.

Tier Structure

The PCPCH model is organized by levels or "tiers" that reflect basic to more advanced primary care home functions. Within each standard tier 1 measures focus on foundational primary care home elements, while tier 2 and tier 3 measures reflect intermediate and advanced functions. PCPCHs attest to meeting measures in the model which are each assigned a point value (0-15). A PCPCH's overall tier level is determined by the number of points earned. The PCPCH model tier structure has remained unchanged since 2011.

Under the current PCPCH model 94% of clinics are recognized as a tier 3, the highest level in the model. Achieving tier 3 PCPCH recognition was intended for clinics that had implemented more advanced primary care home functions. Feedback from stakeholders suggest both providers and payers believe the current tier structure does not hold significant meaning since it does not accurately reflect the level of transformation occurring in a clinic.

In 2012 the committee proposed revising the tier point thresholds so tier 3 was more representative of true clinic-wide transformation.[21] This recommendation was not adopted into the current PCPCH model. The 2015 committee considered a similar revision to the tier structure that was recommended in 2012, but instead elected to recommend expanding the PCPCH model from three tiers to five tiers. The additional tiers segment the current tier 3 clinics to better distinguish clinic capability without causing clinics to "drop a tier." Tier 5 aligns with the current 3 STAR Designation that was introduced in February 2015 to recognize clinics on the forefront of transformation.

[21] Oregon Health Authority. (2012). Standards and Measures for Patient-Centered Primary Care Homes: Final Report of the Patient-Centered Primary Care Home Advisory Committee. Retrieved from http://www.oregon.gov/oha/pcpch/Pages/SAC.aspx

Tier	Thresholds*	Additional Requirements
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65-125 points	+ All must-pass standards
Tier 3	130 – 250 points	+ All must-pass standards
Tier 4	255 - 380 points	+ All must-pass standards
Tier 5 (Current 3 STAR Designation)	255 – 380 points **based on current PCPCH model*	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

Implementation

The committee recommended any revisions to the PCPCH model be implemented in January 2017 citing the following considerations:

- A January implementation date aligns with the Coordinated Care Organization (CCO) PCPCH metric that supports broader health system transformation goals;
- Clinics will have sufficient time to prepare for and implement any operational changes needed to meet the revised PCPCH model standards; and
- PCPCH program staff and content experts will have sufficient time to develop the technical specifications for the revised standards and measures.

Future Areas of Focus

To emphasize the importance of continued primary care home practice transformation, the 2012 committee introduced the concept of measures in development as a means to identify aspirational measures that would be ideal, but are not uniformly achievable to measure in the current system. [22] Building upon that concept, this committee has identified measures, standards and key areas of focus within the model to serve as the foundation for future model refinements (see Appendix C).

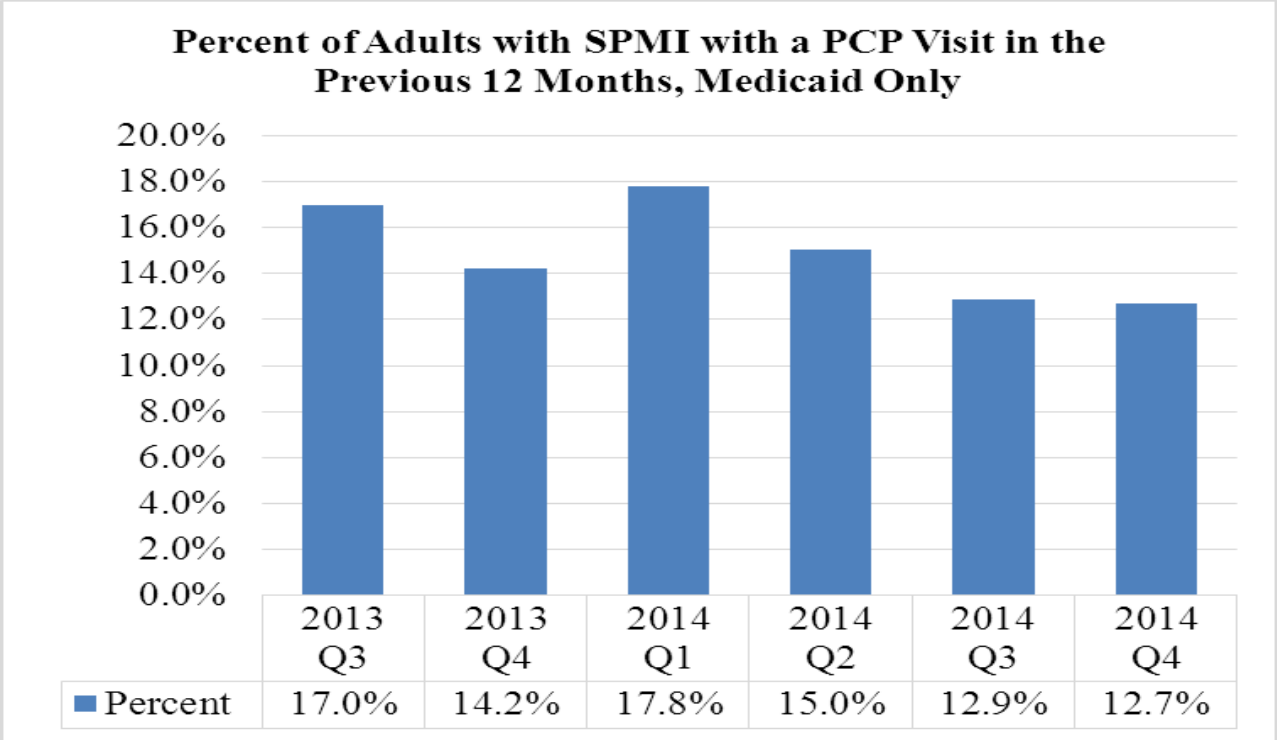
[22] Oregon Health Authority. (2012). Standards and Measures for Patient-Centered Primary Care Homes: Final Report of the Patient-Centered Primary Care Home Advisory Committee. Retrieved from http://www.oregon.gov/oha/pcpch/Pages/SAC.aspx

Behavioral Health Home Standards

Background, Evidence and Sources

It is estimated that between 2011 and 2012, 4.6 percent of Oregonians 18 and older coped with a serious mental illness (SMI), and 21 percent of all adults suffered from any mental illness.[23] A number of factors place people with a serious mental illness, substance use disorders and co-occurring disorders at higher risk of sickness or death, including higher rates of smoking, alcohol consumption, poor nutrition, obesity and lack of exercise.[24] Lack of access to appropriate health care and lack of coordination among behavioral health and general health care providers compound these factors.

OHA data shows that a small percentage of adults with a SMI are accessing services through a Primary Care Provider (PCP) within a 12 month period. The following graph shows 6 quarters of data with the most recent reporting periods demonstrating a decrease in adults with a SMI accessing their PCP within the previous 12 months. This lack of direct contact to primary care services only perpetuates the issues described above.



[23] Center for Behavioral Health Statistics and Quality. (2013). Behavioral Health, United States, 2012 (HHS Publication No. SMA 13-4797). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/sites/default/files/2012-BHUS.pdf

[24] National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (2006). Morbidity and mortality in people with serious mental illness. Alexandria, VA: National Association of State Mental Health Program Directors.

Stakeholders across Oregon have identified the need to provide more integrated physical and behavioral health care services. Several existing and emerging state programs support the adoption of a more integrated model of primary and behavioral health care delivery. In 2012 OHA received an Adult Medicaid Quality grant that included funding for a Behavioral Health Home Learning Collaborative (BHH-LC) which will convene through December 2016. The BHH-LC is working with 10 mental health and chemical dependency treatment clinics to bring primary care services into behavioral health settings that serve persons with serious mental illness and substance use disorders. In 2015 Oregon was awarded a Certified Community Behavioral Health Clinic (CCBHC) planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop an application for a two-year demonstration program that will strength community mental health programs. As previously noted, the Oregon Legislature demonstrated its support for physical and behavioral health care integration with the enactment of Senate Bill 832 which tasked OHA with developing integration standards.

Conceptual Framework

As the committee turned its attention to the development of integration standards, they were encouraged by the co-chairs to envision what the ideal behavioral health system should look like in ten years. It was noted this committee's work is foundational for future health system transformation. With this vision in mind, the committee identified the following concepts that set the framework for how they approached developing standards for the integration of physical health services into behavioral health care settings.

There is no one door to care. As noted in the proceeding section of this report, many Oregonians with a mental health condition are not accessing primary care services. Creating integration standards opens the door to both physical and behavioral health care in a setting that is familiar to the person with a mental health condition. Whether a clinic provides primarily physical health care or primarily behavioral health care, patients who choose a clinic as their "home" should have all their healthcare needs coordinated or provided at that home.

Transformation as a journey. Behavioral health care settings across Oregon are diverse in scope of services, providers, and resources. A model that recognizes this diversity and provides an opportunity for continued practice improvement is ideal to support health system transformation. The committee recommended a tiered structure similar to the PCPCH model that would allow for flexibility in the implementation of standards to accommodate varying organizational resources and sizes.

Be our partner over time. The committee recommended the integration standards be applied to behavioral health provider organizations that serve a population who would benefit the most from receiving ongoing integrated care. This could include persons with serious mental illnesses, substance use disorders or those who cannot be effectively served by traditional primary care programs. It was noted by some committee members that such a defined population could leave out other populations such as children. It was recommended the standards be applied more broadly in the future.

Behavioral Health Home Model

Building on the conceptual discussions, PCPCH program staff drafted a proposed BHH model for the committee to review. The model is based on the current PCPCH model and the Certified Community Behavioral Health Clinic standards, and was informed by the SAMHSA-HRSA Center for Integrated Health Solutions Behavioral Health Home model.

The BHH model is a framework for integrating physical health services into behavioral health care settings in Oregon. The BHH model includes the same six core attributes as the PCPCH model with standards and measures specific to the provision of both physical and behavioral health care services. Over the course of four meetings, the committee reviewed each standard and measure providing recommended revisions to program staff which were incorporated into the final recommended BHH model (see Appendix D).

A principle component of the BHH model is *Standard 3.C - Coordination & Integration with Primary Care.* At several meetings, committee discussion centered on whether the direct provision of primary care services should be a required BHH standard. Opinions were divided; some committee members advocated that all BHHs should have an onsite physical health provider given the often complex needs of people with a mental health condition, while others stated that full integration may not be achievable for all clinics, and patients could still benefit from improved coordination of physical health services in a behavioral health setting. There was committee agreement to raise the bar beyond screening and assessment.

While the BHH model is flexible overall, the committee recommended Standard 3.C be more directive. This decision reflects the committee's compromise on requiring BHHs to provide physical health services. A tier 1 BHH must meet the requirements of Measure 3.C.1, a tier 2 BHH must meet the requirements of Measure 3.C.2 and a tier 3 BHH must meet the requirements of Measure 3.C.3.

- 3.C.1-BHH conducts screenings, links clients to PCPs and coordinates primary care with PCP. BHH has designated staff that serves as bridge between client, BH providers and primary care provider. BHH has a cooperative referral process with primary care providers. Both BHH and primary care staff receive cross training. BHH must assist client identify medical provider who will provide continued care.
- 3.C.2 -BHH is co-located with primary care and provides access to primary care services during a defined percentage of hours that the clinic is open.
- 3.C.3-BHH is integrated with primary care and provides access to primary care services during all clinic hours of operation.

As with the comparable standard in the PCPCH model, the committee recommended the technical specifications for Standard 3.C. clearly define collaboration, co-location and integration, and include a list of definitions from the Agency for Healthcare Research and Quality (AHRQ) to further guide the interpretation of each measure.

Implementation

There is currently no Behavioral Health Home designation by the state. Some of the recommended BHH model standards will be incorporated into the requirements for clinics interested in participating in the CCBHC demonstration. This work is still in development and more information will be available in the first quarter of 2016. Should the state elect to implement a BHH designation program in the future, the committee recommended further refinement of the BHH model including the development of technical specifications for each standard and measure.

Guiding Principles

The first PCPCH Standards Advisory Committee recommended that OHA and others consider the following guiding principles in the application of the proposed standards and measures for Patient-Centered Primary Care Homes. [25] The 2015 committee included these principles in this report to emphasize their continued relevance to health system transformation and their application to both PCPCH and BHH standards. The guiding principles are divided into five broad categories: strategies for payment reform, providing incentives for delivery system change, strategies for primary care home measurement, encouraging continuous improvement, and aligning the health care system around primary care homes. The 2015 committee noted the importance of the strategies for payment reform principles for advancing health system transformation in Oregon.

Strategies for Payment Reform

- Payment reform is an essential step for developing Patient-Centered Primary Care Homes. Currently, primary care clinics use fee-for-service payments to fund essential but unpaid primary care functions such as care coordination. This type of payment model fails to recognize the complexity and intensity of primary care, devalues the work of all members of the primary care team, contributes to overwork and burnout of clinicians, does not assess and reward quality care, and decreases opportunities for meaningful communication between patients and their health care teams.

- The basic primary care home functions proposed in the attached standards and measures (tier 1) should be achievable by most primary care clinics in Oregon (regardless of size, patient mix or geographic location). Additional resources will be required for clinics to achieve many advanced (tier 2 and tier 3) primary care home functions. Requiring primary care clinics to meet advanced primary care home measures without additional resources or an adequate workforce will exacerbate existing workforce shortages and could worsen health disparities in underserved populations.

- Payment for primary care homes should be risk-adjusted based on a broad set of factors that increase the complexity of delivering and coordinating care (e.g. medical complexity, primary language, socioeconomic factors, rates of behavioral risk factors and mental illness, etc.). Risk-adjusted payment models should include adequate payments for all patients, including those in the lowest risk groups.

- Payment mechanisms for primary care homes should include both ongoing payments that adequately support their infrastructure (systems, staffing, etc.) and incentive payments based on outcomes. Whenever possible these payment systems should be aligned across the system, for all payers.

[25] Oregon Health Authority. (2010). Standards and Measures for Patient-Centered Primary Care Homes. Retrieved from http://www.oregon.gov/oha/pcpch/SACdocs/2010%20Standards%20Advisory%20Committee%20Report.pdf

- If there is upfront investment, it is reasonable to expect advanced (tier 3) primary care homes to be accountable, in part, for unnecessary or preventable utilization and the risk-adjusted overall cost of health care within their patient populations. To do this, primary care clinics must have timely access to patient-level cost and utilization data.

Providing Incentives for Delivery System Change

- HB 2009 and the Oregon Health Policy Board believe that providing a primary care home for every Oregonian could move Oregon's health care system towards the "Triple Aim" goals of a healthy population, extraordinary patient care and reasonable costs. Achieving these goals will require moving the entire primary care delivery system towards functioning as "advanced" primary care homes regardless of payer, size, or location.

- Primary care home measures are intended to be applied to an entire clinic or all patients served by a clinic, regardless of whether patients are publically or privately insured. Care coordination and other services provided by a primary care home are of potential benefit to all patients, not just those with specific chronic diseases.

- Any clinic that is willing to assume responsibility for providing comprehensive, longitudinal care to a population of patients (such as a community mental health center) should be eligible to be measured and receive payments as a primary care home.

- Primary care home payments and incentives should reward both current levels of high performance and incremental delivery system improvements.

Strategies for Primary Care Home Measurement

- Primary care home measures should be applied consistently across public and private health payers, to provide clinics with a uniform set of expectations, but with flexibility in how clinics can demonstrate they are meeting the intent of particular measures. Therefore, measures should focus on outcomes whenever possible.

- The process of primary care home measurement should seek to minimize the administrative burden on and cost to individual clinics and provide constructive feedback to primary care clinics. Alignment of metrics across all payers is therefore crucial.
- Evaluation criteria for primary care homes should be transparent to all parties, including consumers, clinics, health plans and purchasers.

- Primary care home performance and improvement over time should be measured using internal clinical data, such as data directly from a clinic's electronic health record and patient and family involvement, in addition to external data, such as claims data, whenever possible.

Encouraging Continuous Improvement

- Learning collaborative and other mechanisms to spread learning and speed delivery system change and integration should be developed and financed in conjunction with efforts to measure primary care homes. Primary care clinics should receive support for participation in learning collaborative; especially those clinics that are early adopters of the PCPCH model and can share their learning with others. OHA's newly launched Patient-Centered Primary Care Institute will provide a broad array of resources over the coming year, including establishing the first PCPCH learning collaborative. Sustainability of these activities beyond 2013 will be critical to maintain support of primary care transformation.

- Developing primary care homes will require clinicians and staff of primary care clinics to develop new skills and take on new roles as members of a primary care team. Efforts to improve the primary care workforce must include both support for continuing education of current clinicians and clinic staff as well as changes in training programs that produce the future primary care workforce.

Aligning the Health System Around Primary Care Homes

- Communication within the health care system is critical to the success of primary care homes. Other health care providers and facilities should be required to identify each patient's primary care home, communicate with them in a timely manner, and participate in care coordination.

- A robust "health care neighborhood" is required to support the primary care home. Clinics should be encouraged to partner with local public health agencies and community organizations to educate patients, identify community health priorities, and develop plans to improve the overall health of their communities. Public Health departments and other agencies and organizations that make up the "health care neighborhood" must have sufficient and stable funding to carry out these roles.

- Primary care home measurement should be integrated and aligned with other efforts to improve health care quality or delivery (e.g. health information technology incentives, quality improvement programs, pay for performance incentives and the development of accountable care organization.

APPENDIX A - 2015 COMMITTEE ROSTER

Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee

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APPENDIX B – PROPOSED REVISIONS TO THE 2014 PCPCH MODEL

The following document summarizes the proposed revisions to the 2014 PCPCH model recommended by the PCPCH Standards Advisory Committee.

Please refer to the following definitions when using this document:

Unchanged: This measure was part of the 2014 criteria and language and/or point values have not changed.
Revised: This measure was part of the 2014 criteria but proposed changes were made to language and/or point values.
New: This measure was not part of the 2014 criteria and is proposed as a new measure to the model.
(D): Data submission to OHA required.

The advisory committee recommended making the standard related to patient experience of care a new must-pass standard (6.C.0) bringing the total number of must-pass standards in the model to 11. Every recognized clinic needs to meet the must-pass standards. The other standards are optional, allowing clinics to accumulate points towards a total that determines their overall tier of PCPCH recognition. The total points available in the PCPCH model with all proposed changes is 390 points (up from a total of 380 points in the 2014 model).

PCPCH CORE ATTRIBUTE **PCPCH Standard** **PCPCH Measures**	**Unchanged, Revised, Deleted or New?**	**Must Pass?**	**Points Available**
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*			
Standard 1.A) In-Person Access			
1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	Unchanged	No	5
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.	Unchanged	No	10
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.	Unchanged	No	15
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.	Unchanged	No	5
Standard 1.C) Telephone and Electronic Access			

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	**Revised**[1]	Yes	0
~~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.~~	**Deleted**	~~No~~	~~5~~
Standard 1.D) Same Day Access			
1.D.1 PCPCH provides same day appointments.	Unchanged	No	5
Standard 1.E) Electronic Access			
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.	**Revised**[2]	No	5
Standard 1.F) Prescription Refills			
1.F.2 PCPCH tracks the time to completion for prescription refills.	**Revised**[3]	No	10
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	**New**	No	15
CORE ATTRIBUTE 2: ACCOUNTABILITY - *"Take responsibility for making sure we receive the best possible health care."*			
Standard 2.A) Performance & Clinical Quality			
2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.	Unchanged	Yes	0
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)	**Revised**[4]	No	5
2.A.2 PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures (D)	**New**	No	10
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)	Unchanged	No	15
Standard 2.B) Public Reporting			
2.B.1 PCPCH participates in a public reporting program for performance indicators.	Unchanged	No	5
2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	Unchanged	No	10

[1] Standard language of 1.C.0 is unchanged but in TA guide it will be revised to incorporate former 1.C.1
[2] Decrease in point value from 15 points to 5 points.
[3] Increase in point value from 5 points to 10 points and replaces 1.F.1
[4] Used to be 2.A.2 and worth 10 points instead of 5 points.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
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.	Unchanged	No	5
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.	Unchanged	No	10
2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	Unchanged	No	15
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.	Unchanged	No	5
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.	Unchanged	No	10
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.	Unchanged	No	15
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.	Unchanged	No	5
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.	Unchanged	No	10
2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	Unchanged	No	15
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - *"Provide or help us get the health care, information, and services we need."*			
Standard 3.A) Preventive Services			

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
3.A.1 PCPCH routinely offers or coordinates recommended preventive services **appropriate for your population** (i.e. age and gender) based on best available evidence **and identifies areas for improvement.**	**Revised**[5]	No	5
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.	Unchanged	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	Unchanged	No	15
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.	**Revised**[5]	Yes	0
Standard 3.C) Mental Health, Substance Abuse, & Developmental Services (check all that apply)			
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.**	**Revised**[5]	Yes	0
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, or developmental providers.**	**Revised**[5]	No	10
3.C.3 **PCPCH provides integrated behavioral health services, including population-based, same-day consultations by providers/behaviorists specially trained in assessing and addressing psychosocial aspects of health conditions.**	**New**	No	15
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.	Unchanged	No	5
Standard 3.E) Preventive Services Reminders			
3.E.1 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.	**Revised**[6]	No	5

[5] Language in bold has been added to measure language.
[6] Used to be 3.E.3 and worth 15 points.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
3.E.2 PCPCH uses patient information, clinical data and evidence-based guidance to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services **and tracks number of unique patients who were sent appropriate reminders.**	**Revised**[7]	No	10
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.**	**Revised**[8]	No	15
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*			
Standard 4.A) Personal Clinician Assigned			
4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	No	15
Standard 4.B) Personal Clinician Continuity			
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Unchanged	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	10
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	15
Standard 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.	Unchanged	Yes	0
Standard 4.D) Clinical Information Exchange			

[7] Used to be 3.E.1 and worth 5 points, language in bold is new.
[8] Used to be 3.E.2 and wroth 10 points, language in bold is new

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	Unchanged	No	15
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.	Unchanged	Yes	0
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.	Unchanged	No	5
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.**	**Revised**[5]	No	5
4.G.2 PCPCH **develops a process**, tracks **and reports** the percentage of patients whose medication regimen is reconciled **at each relevant patient encounter.**	**Revised**[5]	No	10
4.G.3 PCPCH provides Comprehensive Medication Management for appropriate patients and families.	**New**[9]	No	15
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*			
Standard 5.A) Population Data Management (check all that apply)			
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.	**Revised**[10]	No	5
~~5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population~~.	**Deleted**	~~No~~	~~5~~
~~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.~~	**Deleted**	~~No~~	~~5~~
5.A.2 PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior.	**New**	No	10
Standard 5.B) Electronic Health Record			

[9] Replaces former 4.G.3 related to Meaningful Use.
[10] 5.A.1a and 5.A.1b were combined into 5.A.1

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
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.	Unchanged	No	15
Standard 5.C) Complex Care Coordination (check all that apply)			
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."	**Revised**[5]	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	Unchanged	No	10
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.	Unchanged	No	15
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.	Unchanged	No	5
Standard 5.E) Referral & Specialty Care Coordination (check all that apply)			
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.	Unchanged	No	5
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).	Unchanged	No	10
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.	Unchanged	No	15
Standard 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.	Unchanged	Yes	0
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).	Unchanged	No	5

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
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 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.	Unchanged	Yes	0
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.	Unchanged	No	5
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.	Unchanged	No	5
6.B.2 More than 10% of unique patients are provided patient-specific education resources.	Unchanged	No	10
6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	Unchanged	No	15
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.	**Revised**[11]	**Yes**	0
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.**	**Revised**[12]	No	10
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.	**Revised**[12]	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities			

[11] Used to be 6.C.1 but is now a new must-pass standard.

[12] Language in bold is new, also changed from annually to every two years.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
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.	Unchanged	No	5

APPENDIX C – FUTURE AREAS OF FOCUS

The committee identified the following measures, standards, and key areas of focus within the model to serve as the foundation for future model refinements.

Model Alignment

Although the PCPCH model and the proposed BHH model share a similar structure of core attributes, standards and measures, the models are not completely aligned. Defining behavioral and physical health integration through the development of BHH standards and the strengthening of existing PCPCH standards moves transformation forward, but two separate models could perpetuate siloed care for patients. The committee recommended future revisions of both models focus on alignment of the standards and measures to ultimately achieve one "health home" model of care delivery applicable to any care setting.

Standard 5.A – Population Data Management

The proposed revisions to Standard 5.A are expected to improve how PCPCHs collect and use data to proactively manage their patient population with a specific disease or health care need (see page 11 of the report). Revisions to this standard also included the addition of a new measure specifically addressing risk stratification and management. The committee recommended a high value measure with defined risk stratification parameters be considered for future model refinement.

Multi-payer State Strategy to Support Primary Care

Through its health system transformation efforts, Oregon is counting on primary care providers to change care delivery but payment incentives are not changing at the same pace to adequately support the adoption of new care models. There are numerous pilot projects occurring across the state, but pilot project parameters and payer participation vary widely. This leaves some providers under-supported and others trying to manage different initiatives and incentives across payers. To advance primary care transformation, the committee asserted the need for a multi-payer strategy to support primary care providers that aligns payments with outcomes.

APPENDIX D - BEHAVIORAL HEALTH HOME MODEL

1. Access to Care					
1.A In-Person Access	1.B After Hours Access	1.C Telephone & Electronic Access	1.D Same Day Access	1.E Electronic Access	1.F Prescription Refills
1.A.1 BHH surveys a sample of its population on satisfaction with in-person access to care.	1.B.1 BHH offers access to in-person care for bh services at least 4 hours weekly outside traditional business hours.	1.C.0 BHH provides continuous access to behavioral health advice by telephone. **(Must-pass)**	1.D.1 BHH provides same-day and walk-in appointments for BHH services.	1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the BHH provides clients with an electronic copy of their health information upon request.	1.F.1 BHH tracks the time to completion for prescription refills.
1.A.2 BHH surveys a sample of its population using the Experience of Care & Health Outcomes (ECHO) or CAHPS survey tools on consumer satisfaction with access to care	1.B.3 (New) BHH offers access to in-person care for **primary care services** at least 4 hours weekly outside traditional business hours.	1.C.3 (New) BHH provides continious access to primary care advice by telephone that is then documented in the client's medical record.	1.D.3 (New) BHH provides on-site same day appointments for primary care services.		
1.A.3 BHH surveys a sample of its population using the Experience of Care & Health Outcomes (ECHO) or CAHPS survey tools, and meets a benchmark on consumer satisfaction with access to care.					

2. Accountablity						
2.A Performance & Clinical Quality	2.B Public Reporting	2.C Consumer/Family Involvement in QI	2.D Quality Improvement	2.E Ambulatory Sensitive	2.F Care Team Involvement (New)	2.G Evidence-based Data-Driven Care (New)
2.A.0 BHH tracks one quality metric from the core or menu set of PCPCH Quality Measures. **(Must-pass)**	2.B.1 BHH participates in a public reporting program for performance indicators.	2.C.1 BHH involves consumers, caregivers, and consumer-defined families as advisors on at least one quality or safety initiative per year	2.D.1 BHH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and client experience.	2.E.1- BHH tracks selected utilization measures most relevant to their overall or an at-risk patient population.	2.F.1 BHH uses an interdisciplinary team including peer supports & involves consumer/family in treatment planning & care coordination activities. A care coordination agreement is developed that helps establish which provider is reasonable for what aspects of care & its coordination.	2.G.1 BHH uses data-driven, evidence-based care to guide treatment decisions and delivery of care including use of validated assessment tools, information systems like registeries to track data over time.
2.A.2 BHH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH/BHH Quality Measures.	2.B.2 Data collected for public reporting programs is shared within the BHH (with providers & staff) for improvement purposes.	2.C.2 BHH has established formal mechanism to integrate consumer/caregiver/consumer-defined family advisors as key members of quality, safety, prog. Dev. &/or ed. imp. activities.	2.D.2 BHH 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.G.2 BHH embeds clinical guidelines into routine delivery of care.
2.A.3 BHH 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		2.C.3 Consumer caregiver, and consumer-defined family advisors are integrated into the BHH and function in peer support or in training roles.	2.D.3 BHH has doc. clinic-wide imp. strategy w/ performance goals derived from community, consumer, family, caregiver, & other team feedback, publicly reported measures, & areas for clinical & operational imp. identified by practice. The strategy includes a QI methodology, multiple imp. related projects, & feedback loops			

3. Comprehensive Whole-Person Care				
3.A Preventive Services	3.B Provision of Services	**3C Coordination & Integration with Primary Care (3.C.1 is must-pass for Tier 1, 3.C.2 is must-pass for Tier 2, 3.C.3 is must-pass for Tier 3)**	3.D Comprehensive Health Assessment & Intervention	3.E Preventive Services Reminders
3.A.1 BHH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	3.B.0 BHH reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation. **(Must-pass)**	3.C.1 BHH conducts screenings, links consumers to PCPs and coordinates primary care with PCP. BHH has designated staff that serves as bridge between consumer, bh providers and primary care provider. BHH has a cooperative referral process with primary care providers . Both BHH and primary care staff receive cross training. BHH must assist consumer identify medical provider who will provide continued care.	3.D.1 BHH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	3.E.1 BHH uses consumer information, clinical data, and evidence-based guidelines to generate lists of consumer who need reminders and to proactively advise consumers/families/caregivers and clinicians of needed services.
3.A.2 BHH 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 BHH consumer population	3.B.2 (new) BHH incorporates prevention and wellness support services including nutrition consultation, health ed & literacy, peer specialists & self-help/management programs into individualized wellness plans.	3.C.2 BHH is co-located with primary care and provides access to primary care services for a defined percentage of hours that the clinic is open.		3.E.2 BHH tracks the number of unique consumers who were sent appropriate reminders.
3.A.3 BHH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	**3.C.3 (New) BHHs offer or coordinate 24/7 access to crisis management services**	3.C.3 BHH is integrated with primary care and provides access to primary care services during all clinic hours of operation.		3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the BHH sends reminders to consumers for preventative/follow-up care.

4. Continuity				
4.A Organization of BHH Info	4.B Clinical Info Exchange	4.C Specialized Care Setting Transitions	4.D Planning for Continuity (See separate sheet for options)	4.E Medication Reconcilation
4.A.0 BHH maintains a health record for each consumer that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language; and updates this record as needed at each visit. **(Must-pass)**	4.B.3 BHH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	4.C.0 BHH has a written agreement with its usual hospital providers or directly provides routine hospital care. **(Must-pass)**	4.D.1 BHH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	4.E.1 Upon receipt of a consumer from another setting of care or provider of care (transitions of care) the BHH performs medication reconciliation.
				4.E.2 BHH tracks the percentage of consumers whose medication regimen is reconciled.
				4.E.3 The BHH makes and documents reasonable attempts to determine any medications prescribed by other providers for BHH consumers and to provide such information to other providers not affiliated with the BHH to the extent necessary for safe and quality care.

5. Coordination and Integration					
5.A Population Data Management (Check all that apply)	5.B Electronic Health Record	5.C Care Coordination	5.D Test & Result Tracking	5.E Referral & Speciality Care Coordination	5.F End of Life Planning
5.A.1a BHH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its consumer population.	5.B.3. The BHH establishes or maintains a HIT system that includes EHRs. The HIT system has the capability to capture structured info in consumer records (including demographic information, diagnoses, & med lists), provide clinical decision support, & electronically transmit prescriptions to pharmacy. Uses HIT system to conduct activities such as pop. health management, QI, reducing disparities, & for research & outreach.	5.C.0 BHH demonstrates that members of the health care team have defined roles in care coordination for consumers, and tells each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care. **(Must-Pass)**	5.D.1 BHH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to consumers and families with interpretation, as well as to ordering clinicians.	5.E.1 BHH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to consumers and/or caregivers and clinicians.	5.F.0 BHH has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from these services. **(Must-pass)**
5.A.1b BHH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its consumers using up-to-date information		5.C.3 BHH describes and demonstrates its process for identifying and coordinating of consumers with complex care needs. BHH develops an individualized written care plan with consumers/families. 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. BHH uses single shared care plan that whole team uses and that addresses physical, behavorial, and wellness needs of client. Care plan must document specific services and supports to be provided, arranged or coordinated to assist consumer/family to achieve intended outcomes.	5.D.3 (NEW) BHH tracks outcomes related to tests and results.	5.E.2 BHH demonstrates active involvement and coordination of care when its consumers receive care in specialized settings (hospital, SNF, long term care facility).	
				5.E.3 BHH tracks referrals and cooperates with community service providers outside the BHH such as social services, housing, ed systems, & employment opportunities as necessary to facilitate wellness and recovery of the whole person.	

6. Person and Family Centered			
6.A Language / Cultural Interpretation	6.B Education & Self-Management Support	6.C Experience of Care (Will be changed to relfect new language for this standard related to	6.D Communication of Rights, Roles & Responsibilites
6.A.0 BHH offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice. **(Must-pass)**	6.B.1 BHH has a process for identifying consumer-specific educational resources and providing those resources to clients when appropriate.	6.C.1 BHH surveys a sample of its consumers 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 consumer experience of care survey is the ECHO or CAHPS survey tools.	6.D.1 BHH has a written document or other educational materials that outlines BHH and consumer/family rights, roles, and responsibilities and has a system to ensure that each consumer or family receives this information at the onset of the care relationship.
6.A.1 BHH translates written consumers materials into all languages spoken by more than 30 households or 5% of the practice's consumers population.	6.B.2 More than 10% of unique consumers are provided consumer-specific education resources. **BHH tracks usage of these resources and outcomes that occur as a result of usage.**	6.C.2 BHH surveys a sample of its population at least annually on their experience of care using the ECHO or CAHPS survey tools. The consumer survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.	
	6.B.3 More than **25%** of unique consumers are provided consumer-specific education resources and self-management services. **BHH tracks usage of these resources and outcomes that occur as a result of usage.**	6.C.3 BHH surveys a sample of its population at least annually on their experience of care using the ECHO or CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.	