Patient-Centered Primary Care Home 2017 Recognition Criteria
Quick Reference Guide

Oregon Health Authority

Last Updated March 2017

This guide is intended to provide a brief overview of Oregon's Patient-Centered Primary Care Home (PCPCH) Program criteria for recognition that is effective January 1, 2017. The complete technical specifications for all measures are available at www.PrimaryCareHome.oregon.gov or by clicking here.

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 a new measure to the model.
(D): Data submission to OHA required at time of attestation.

There are 11 must-pass measures every clinic must meet to become recognized. The other standards are optional, allowing clinics to accumulate points towards a total that determines their overall tier of PCPCH recognition. A clinic's overall tier of recognition is determined by the following:

Tier Level	Point Range	Additional Required Criteria
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
5 STAR (Tier 5)	255 - 380 points	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

Important Note: Any clinic applying for PCPCH recognition must review the technical specifications prior to submitting an application. The technical specifications describe each measure in more detail, including what documentation the clinic must have to support their attestation. Clinics must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted. The technical specifications for the2017 criteria are available on the program website or by clicking here.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, 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			
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Revised	**Yes**	0
Standard 1.D) Same Day Access			
1.D.1 PCPCH provides same day appointments.	Unchanged	No	5
Standard 1.E) Electronic Access			
1.E.1 PCPCH provides patients with an electronic copy of their health information upon request using a method that satisfies either Stage 1 or Stage 2 Meaningful Use measures.	Revised	No	5
Standard 1.F) Prescription Refills			
1.F.2 PCPCH tracks the time to completion for prescription refills.	Revised	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	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

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, or New	Must Pass	Points Available
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
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

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, or New	Must Pass	Points Available
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			
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	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	**Yes**	0
Standard 3.C) Behavioral Health 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	**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, and developmental providers.	Revised	No	10
3.C.3 PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.	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 PCPCH sends reminders to patients for preventative/follow-up care using a method that satisfies either Stage 1 or Stage 2 meaningful use measures.	Revised	No	5
3.E.2 PCPCH uses patient information, clinical data and evidence-based guidance to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders.	Revised	No	10

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, or New	Must Pass	Points Available
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	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			
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			

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, or New	Must Pass	Points Available
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	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	No	10
4.G.3 PCPCH provides Comprehensive Medication Management for appropriate patients and families.	New	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	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			
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	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)			

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, or New	Must Pass	Points Available
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 demonstrates 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
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	**Yes**	0

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, or New	Must Pass	Points Available
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	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	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities			
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	Unchanged	No	5