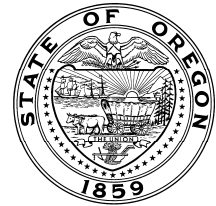

**Office for
Oregon Health Policy and Research**



Standards and Measures for Patient Centered Primary Care Homes

**Final Report of the
Patient Centered Primary Care Home
Standards Advisory Committee
February 2010**

**Updated by the
Pediatric Standards Advisory Committee
November 2010**

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EXECUTIVE SUMMARY

The Patient Centered Primary Care Home (PCPCH) is a new model of primary care that has received attention in Oregon and across the country for its potential to advance the “triple aim” goals of health reform: a healthy population, extraordinary patient care and reasonable costs. Patient Centered Primary Care Homes achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs and a patient and family centered approach to all aspects of care.

During the 2009 legislative session, the Oregon Legislature enacted House Bill 2009, which created the Oregon Health Authority (OHA) and established a Patient Centered Primary Care Home Program within the Office for Oregon Health Policy and Research (OHPR). The goals of the program are to develop strategies to identify and measure patient centered primary care homes, promote their development, and encourage populations covered by the Oregon Health Authority to receive care in this new model.

In order to assist OHPR in developing strategies to identify and measure patient centered primary care homes, the OHA Director appointed and convened two committees. The first Patient Centered Primary Care Home Standards Advisory Committee was made up of a diverse group of Oregon stakeholders including patients, clinicians, health plans and payers. Over the course of seven meetings between October 2009 and January 2010, the committee developed six core attributes (Access to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration and Person and Family Centered Care) and a number of standards that describe the care delivered by patient centered primary care homes. 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.

Using the framework of the core attributes and standards, the committee also developed a set of detailed patient centered primary care home measures. The core attributes, standards and measures are intended as a tool for the Oregon Health Authority, policymakers and other Oregon stakeholders seeking to assess the degree to which primary care clinics are functioning as patient centered primary care homes and promote widespread adoption of the model.

Recognizing that the key drivers of health for children differ from those for adults, in August 2010 OHPR convened the Patient Centered Primary Care Home Pediatric Standards Advisory Committee. This committee was composed of a wide array of pediatric stakeholders, including providers, patient advocates, educational and social services experts. Over the course of five public meetings from August through November 2010, the committee further refined the standards and measures to ensure unique aspects of caring for children were captured.

Both committees believe Oregonians will realize significant benefits if the primary care delivery system across Oregon adopts the patient centered primary care home model of care. However, missteps in application of the proposed measures could worsen the current financing and workforce challenges facing primary care, and ultimately reduce the ability of Oregonians to access high quality health care. The first committee developed a number of guiding principles to assist policymakers in implementing the proposed measures in a way most likely to achieve the triple aim goals. 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 pediatric standards advisory committee endorsed these guiding principles of adoption. In addition, the pediatric standards advisory committee felt strongly that articulating the ways care delivery differs across the age spectrum is critical for successful implementation of the model.

A key theme which emerged from both committees' deliberations was that of flexibility in application. A concerted effort was made to develop attributes, standards and measures drawing from other national and state models and the best available evidence. At the same time the committees felt implementation of the model must be done in a forward-thinking manner, in order to stay true the state's vision of a fully developed primary care home, while still allowing innovation, collaboration, and ongoing evaluation and improvement of the measures.

INTRODUCTION

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.^{1,2} The HFB identified the development of Patient-Centered Primary Care Homes³ as a central strategy for improving the health care delivery system.

In its report, [Aim High: Building a Healthy Oregon](#), the HFB articulated that Patient Centered Primary Care Homes would help achieve the “triple aim” in the following ways:

A Healthy Population

- Care is focused on wellness, prevention and chronic disease management
- Clinics actively evaluate the needs of the population they serve and improve their care

Extraordinary Patient Care

- Patients have personal, continuous relationships in patient-centered clinics
- Services people want and need are easily available
- Patients’ health information is available to them and their clinicians when it is needed
- Individual wishes about end-of-life care are known and followed

Reasonable Costs

- Care is coordinated, reducing duplication and medical errors
- Chronic diseases are managed or prevented, reducing utilization of expensive acute services

The conceptual work of the Health Fund Board on primary care homes was incorporated into two pieces of legislation enacted during the 2009 legislative session. HB 2009 created the Oregon Health Authority, established the Oregon Health Policy Board, and established a Patient Centered Primary Care Home program within the Office for Oregon Health Policy and Research (OHPR). HB 3418 required the Oregon Health Authority (OHA) to study the feasibility of alternative payment models for primary care homes within the Medicaid program. This report contains the findings of two advisory committees convened to assist OHPR in the first phase of its Patient Centered Primary Care Home Program: developing standards and measures for Patient Centered Primary Care Homes. The recommendations, definitions and strategies contained in this report will inform the Oregon Health Policy Board and future executive and legislative bodies on state priorities, while dovetailing with national efforts to transform primary care.

WORK OF THE PATIENT-CENTERED PRIMARY CARE HOME COMMITTEES

Key Tasks and Work Products

Enacted HB 2009 created a Patient Centered Primary Care Home (PCPCH) Program within OHP and specified five key activities of the program:

1. ***Define core attributes of the patient centered primary care home*** to promote a reasonable level of consistency of services provided by patient centered primary care homes;
2. ***Establish a simple and uniform process to identify patient centered primary care homes*** that meet the core attributes defined by OHP;
3. ***Develop uniform quality measures for patient centered primary care homes*** that build from nationally accepted measures and allow for standard measurement of patient centered primary care home performance;
4. ***Develop uniform quality measures for acute care hospital and ambulatory services*** that align with the patient centered primary care home quality measures; and
5. ***Develop policies that encourage the retention of, and the growth in the numbers of, primary care providers.***

The PCPCH Standards Advisory Committee was appointed by the OHA Director in October 2009 to develop policy recommendations around the first three objectives above. The committee held seven public meetings between November 2009 and January 2010.

The PCPCH Pediatric Standards Advisory Committee was appointed by the OHA Director in August 2010 to further refine the attributes, standards and measures. The committee held five public meetings between August 2010 and November 2010.

The complete committee rosters can be found in Appendix A. In addition meeting materials and audio recordings of each meeting are available on the OHP website at www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/PCPCHStandardsAdvisoryCommittee.shtml).

The committees produced three principle products, which are discussed in detail below:

1. Proposed core attributes and standards for primary care homes,
2. A detailed set of proposed measures for primary care homes, and
3. Guiding principles for the application of primary care home measures.

Background and Sources

In addition to the committees' work, OHP staff reviewed prior work on the primary care home⁴ including the work of the Oregon Health Fund Board and its Delivery System Subcommittee, met with numerous experts and stakeholders across Oregon and conducted extensive background research on primary care home policy nationally and in other states to develop the contents of this report. A brief discussion of the literature and measurement models used to inform both committees' work follows.

A number of groups and authors have defined the core attributes of primary care based on a rich body of research.^{5,6,7,8} These definitions focus on four core attributes or domains: access to care, continuity, comprehensiveness and coordination. In addition to these core primary care domains, the development of the chronic care model (CCM) by Wagner and colleagues advanced the state of the art for chronic disease management in a primary care setting.⁹ The CCM added new tools to the primary care toolbox, including the use of multidisciplinary care management teams, electronic disease registries, facilitation of patient self-management and provider decision-support using evidence-based guidelines.

The “Medical Home” concept, first articulated within the pediatric community in the 1960’s, incorporates both the core primary care domains and tools of the chronic care model into a single definition of the roles and functions of a primary care clinic. The standards advisory committees incorporated a diverse set of national and state-level definitions of what composes a medical home into the Oregon definitions found in this report. The most commonly cited medical home definition is the 2007 “Patient Centered Medical Home” principles endorsed by the AAFP, AAP, ACP and AOA.¹⁰ Within Oregon, The Delivery Systems Committee of the Oregon Health Fund Board included in its recommendations a definition of an “Integrated Health Home” that mirrors the 2007 joint principles.¹¹ The Oregon Legislature also endorsed a similar set of core “Primary Care Home” attributes in 2009 in enacted HB 3418.¹² The NCQA Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) certification¹³ was reviewed, including criticisms that the model is overly focused on care coordination and health information technology, places too large an administrative and cost burden on practices, and omits important primary care features such as comprehensiveness and person-focused care.^{14,15,16,17} Other national and state models, definitions and statements incorporated into the committees’ work included the American Academy of Pediatrics Policy Statement on the Medical Home,¹⁸ the Assessment of Chronic Illness Care (ACIC) tool developed at the MacColl Institute for Healthcare Improvement,^{19,20} the Primary Care Assessment Tool (PCAT) developed by Barbara Starfield and colleagues,²¹ and the state of Minnesota rules for certification of Health Care Homes.²²

The evidence that medical homes improve the structure, processes and outcomes of care is emerging. There is an extensive body of literature supporting the association between a robust primary care system and important health or health system outcomes. Authors have defined a robust primary care system as being primary care focused,^{23,24,25,26} consisting of an increased percentage of primary care providers within the health system,^{27,28,29,30,31} incorporating the four primary care domains,^{32,33,34,35,36,37} and incorporating CCM concepts for chronic disease management.³⁸ Associated health system outcomes include higher health care quality, decreased costs, decreased inappropriate or unnecessary utilization of health care services and increased patient and provider satisfaction.^{39,40,41,42,43,44,45} A list of sources cited is provided in Appendix E.

PCPCH Core Attributes and Standards

The PCPCH Core Attributes and Standards build on the conceptual work of the HFB, the Oregon Legislature and other national and state efforts to describe the primary care home concept. They are intended to establish a common framework for understanding the structure and functions of a primary care home from the patient and family perspective. The committees felt strongly that using patient-centered language would help clarify the benefits of a primary care home to patients and the general public. The six core attributes developed by the committee are shown in Figure 1.

Figure 1: Core Attributes of Patient Centered Primary Care Homes

<p>ACCESS TO CARE <i>“Be there when we need you.”</i></p>
<p>ACCOUNTABILITY <i>“Take responsibility for making sure we receive the best possible health care.”</i></p>
<p>COMPREHENSIVE WHOLE PERSON CARE <i>“Provide or help us get the health care, information, and services we need.”</i></p>
<p>CONTINUITY <i>“Be our partner over time in caring for us.”</i></p>
<p>COORDINATION AND INTEGRATION <i>“Help us navigate the health care system to get the care we need in a safe and timely way.”</i></p>
<p>PERSON AND FAMILY CENTERED CARE <i>“Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness.”</i></p>

Within each core attribute, the committees identified “Standards” that represented particularly important domains of the broad core attribute. For example, under the Access to Care core attribute, the committee identified three standards: in-person access, telephone and electronic access and administrative access. As with the core attributes, the committee felt it was important to describe the primary care home functions within each standard from the patient and family perspective. A list of the standards under each core attribute is shown in Figure 2 and the complete description of each core attribute and standard is found in Appendix B.

The proposed core attributes and standards are similar to the prior work of the HFB and other national and state descriptions of the primary care home concept. However, framing these concepts in accessible, patient and family centered language is a unique facet of the process in Oregon. In addition, the core attributes and standards are clearly aspirational. They envision the ideal functioning of a re-designed primary care system capable of achieving the triple aim goals and delivering on the Health Policy Board’s vision of “world class health” for every Oregonian.

Figure 2: Patient Centered Primary Care Home Standards

<p>Access To Care In-Person Access Telephone and Electronic Access Administrative Access</p> <p>Accountability Performance Improvement Cost and Utilization</p>	<p>Continuity Provider Continuity Information Continuity Geographic Continuity</p> <p>Coordination And Integration Data Management Care Coordination Care Planning</p>
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<p>Comprehensive Whole Person Care Scope of Services</p>	<p>Person And Family Centered Care Communication Education and Self-Management Support Experience of Care</p>
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PCPCH Measures

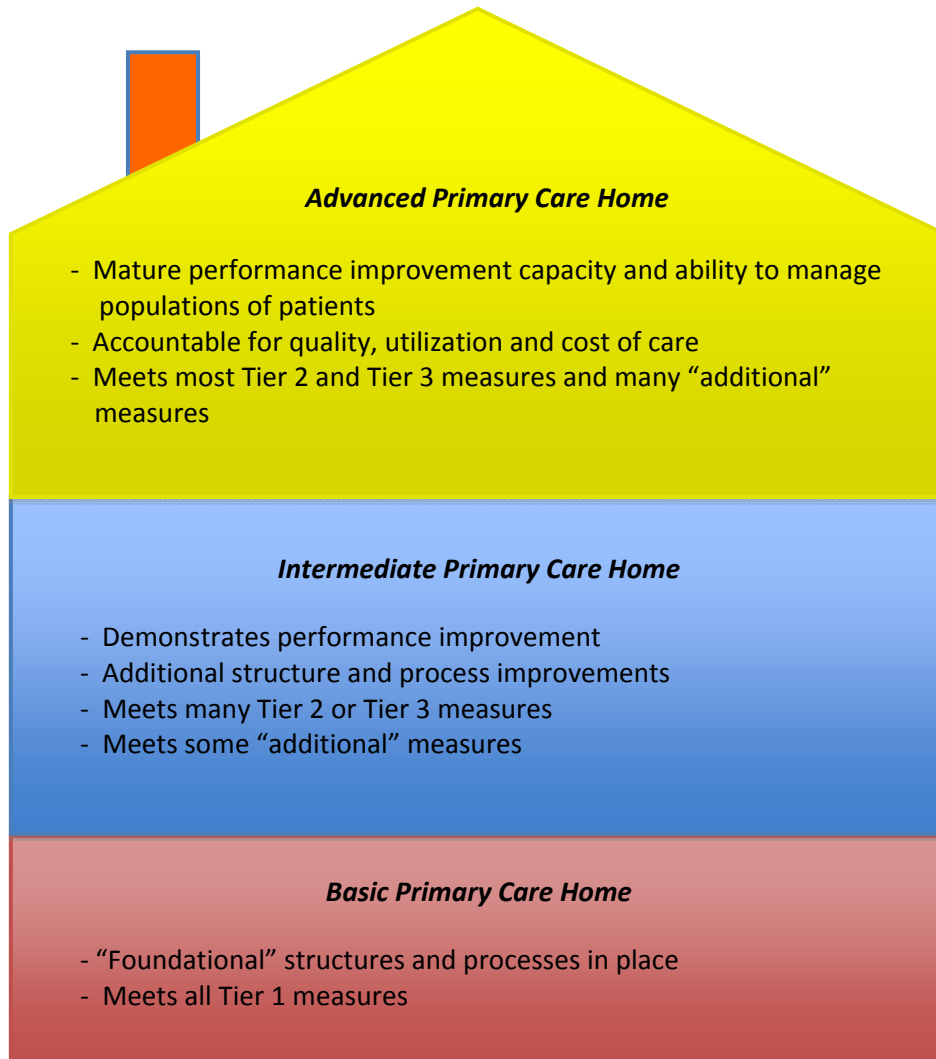
The committees used the core attributes and standards to develop a more detailed set of PCPCH measures. The proposed measures should be viewed as measurement concepts, providing a blueprint for the changes needed to move from today’s primary care system to a more ideally functioning system. The proposed measures are intended as a framework to guide recognition of clinics and organizations currently delivering some primary care home functions, and to support payment reform or other incentives to allow care organizations to transform to advanced, high-quality primary care homes.

The proposed measures are divided into levels or “tiers” that reflect basic to more advanced primary care home functions. Tier 1 measures focus on foundational primary care home elements that the committees felt should be achievable by most primary care clinics in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advanced functions, with a focus on demonstrating improvements in care processes or outcomes. The committees also developed a number of “additional” measures, which are not associated with a particular tier. These measures represent “value added” primary care home functions that a clinic may choose to implement depending on its capacity and the needs of its patient population.

In proposing three tiers of primary care home measures, the committees did not intend to suggest that a clinic should be required to meet all measures at Tiers 2 and 3 or that clinics should progress sequentially from Tier 1 to Tier 3. For example, an individual clinic could be functioning at an intermediate level while meeting some Tier 2, some Tier 3, and some additional measures. An overview of the functional capacity of basic, intermediate and advanced primary care homes, as this relates to the proposed measures, is shown in Figure 3.

The proposed primary care home measures should be considered a starting point. Measures will need to evolve over time as primary care practices become more sophisticated in coordinating and managing the care of individuals and populations. An overview of primary care home measures by tier is provided in Appendix C and a detailed table of all measures is attached in Appendix D.

Figure 3: Functional Capacity of Basic, Intermediate and Advanced Primary Care Homes



Guiding Principles

The Health Policy Board and others have recognized that the current delivery system is not sustainable and does not produce optimal health or health care for Oregonians. However, the committees expressed concerns that primary care is among the most vulnerable components of the health care delivery system and faces a variety of challenges, including a declining workforce, increased fragmentation of care, high administrative burdens and many unpaid services.

While the committees felt that thoughtful and gradual movement towards the care model envisioned in the proposed PCPCH measures could produce the benefits envisioned by the Health Policy Board, they also expressed concern that mis-application of the proposed measures could worsen the current challenges facing primary care, especially in rural and underserved communities in Oregon.

The PCPCH Standards Advisory Committee and the Pediatric Standards Advisory Committee recommends that the Oregon Health Authority and others consider the following guiding principles in the application of the proposed standards and measures for Patient Centered Primary Care Homes. Guiding principles are divided into broad categories: strategies for payment reform, providing incentives for delivery system change, strategies for primary care home measurement, encouraging continuous improvement, aligning the health care system around primary care homes, and unique aspects of care for pediatric populations.

Strategies for Payment Reform

1. Payment reform is an essential step for developing Primary Care Homes. Currently, primary care clinics use fee-for-service payments to fund essential but unpaid primary care functions such as care coordination and integration. The current 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 team.
2. The basic Primary Care Home functions proposed in the attached standards and measures (tier 1) may require changes to the existing care delivery model, but 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.
3. 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.
4. Payment mechanisms for Primary Care Homes should include both ongoing payments that adequately support Primary Care Home infrastructure (systems, staffing, etc.) and incentive payments based on outcomes.
5. 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. A common set of cost and utilization measures should be developed and applied consistently across payers (see possible measures below). These measures should be based on a primary care home's entire patient population, should be appropriate to that population, and should be risk adjusted as discussed above. In addition, primary care clinics must have timely access to patient-level cost and utilization data for care delivered outside the Primary Care Home.

Examples of standardized utilization measures could include:

- ER visits (total or among high users)
- Re-admissions
- Admissions for ambulatory sensitive conditions
- Bed days/1000 patients
- High cost imaging

- Duplicated tests
- Generic medication prescribing

Examples of standardized cost of care measures could include:

- Total cost of care for pts with certain conditions
 - Cost of care in last 6 months of life
 - Cost of specialty care
 - Cost of diagnostic imaging
 - Cost of medications
6. It is crucial to consider the trajectory of pediatric care across a lifetime when developing any revised payment methodologies. The core functions of a PCPCH caring for children, including developmental screening and promotion, anticipatory guidance, and immunizations, allow children to develop into healthy, productive adults. Accordingly, any investment in improving these functions within the PCPCH will likely not produce improved outcomes or decreased expenditures for a significant amount of time. It is imperative to acknowledge, when viewed across the lifespan, the multiplier effect for investment in health outcomes is greatest in childhood. As such, enhanced payment opportunities for the care of children must be considered in any discussion of resource and cost savings allocation.

Providing Incentives for Delivery System Change

7. The Oregon Health Fund Board felt 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.
8. 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 or special health care needs.
9. 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.
10. Primary Care Home payments and incentives should reward both current levels of high performance and incremental delivery system changes.

Strategies for Primary Care Home Measurement

11. Primary Care Home measures should be applied consistently across public and private health plans, 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.
12. 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. Purchasers should consider measuring and/or recognizing primary care homes through a single, centralized entity that forms a positive relationship with primary care practices. The Ambulatory Records Certification (ARC) collaborative developed by the Oregon Medical Association (OMA) in the 1990's was a successful Oregon example of such an entity. In addition, certification processes should be aligned across state and national efforts.

13. Evaluation criteria for Primary Care Homes should be transparent to all parties, including consumers, clinics, health plans and purchasers.
14. 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

15. The measures of Primary Care Home roles and functions should evolve over time as the delivery system changes and successful new models of care emerge. The state should establish a process to regularly review and update Primary Care Home standards and measures. A number of important areas should be considered in the development of future measures, including:
 - Cultural competency
 - Integration of physical health, mental health and developmental services
 - Understanding patients in context (social history and impacts on health)
 - Roles of the primary care home in community health improvement and public health
 - Involving patients and families in the primary care home
16. Learning collaboratives 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 collaboratives, especially those clinics that are early adopters of the Primary Care Home model and can share their learning with others.
17. 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 and changes in training programs that produce the future primary care workforce.

Aligning the Health System Around Primary Care Homes

18. 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 the Primary Care Home in a timely manner, and participate in care coordination.
19. A robust "health care neighborhood" is required to support the Primary Care Home. Primary Care Homes 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.
20. 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 development of accountable care organizations).

Aspects of Care for a Pediatric Population

The Pediatric Standards Advisory Committee was formed in response to the recognition that children have medical, social, emotional and developmental needs which differ from adults. These needs must be integrated within new models of primary care in order to effect the greatest change in the health and well-being of Oregon's children. Throughout the committee's deliberations, several key themes emerged to consider when envisioning how to structure a primary care home that serves pediatric and adolescent populations.

21. Preventive services: Provision of preventive services is central to maintaining a healthy population. This is particularly salient for the child and adolescent population. A PCPCH that cares for children must be able to provide or coordinate recommended preventive services, such as immunizations.
22. Functioning within a family unit: Children exist and function within a family unit. Focusing solely on the child without consideration of the broader family context will not create optimal conditions for health and development. In addition, negative family experiences can profoundly impact the health, social capacity, and developmental trajectory of the child. For this reason the primary care home must emphasize family centered care, should be versed in eliciting family strengths and challenges, and should have the resources or coordination capacity to ensure these needs are addressed. In addition, communication with patients and families should be provided in a culturally appropriate manner, at an age and literacy level allowing effective transmission of information.
23. Nonclinical locations of care: Children spend time and receive substantial amounts of care in different domains outside of the home, such as schools, Head Start and daycare centers, and via the Women, Infants and Children program. Eventually, having a meaningful impact on creating optimal child health and development will mean augmenting the in-office or in-hospital care relationship to address the broader care context of the child. To this end the primary care home should have the capacity and resources to build care relationships to other domains. Over time this relationship should evolve, and eventually may move beyond information sharing to include provision of direct medical care as well as social and educational support within nontraditional settings.
24. Care coordination: Care coordination within the primary care home must be structured and incentivized in a way that is applicable to the patient population served. Care coordination takes place across a spectrum, from episodic and time-limited to longitudinal. For example, a patient with a self-limited injury or illness may need intensive coordination for a set period of time, while an adult with a chronic disease or child with special health care needs may require regular, longitudinal care coordination to prevent unnecessary hospitalization and increase quality of life. In addition, the pediatric population in general may benefit most from care coordination with nonclinical entities such as schools, Early Intervention, foster care, and public health, while adults with chronic diseases may benefit most from coordination among specialists and clinical care entities.
25. Transitions of care: Providers who care for children do so across a continuum of ages and developmental stages. Individuals with special health care needs and complex, chronic conditions typically require multispecialty care to varying degrees throughout their childhood, adolescence and into adulthood. However due to financial, insurance, and system-based barriers, these individuals frequently do not successfully negotiate the transition from pediatric to adult providers, which can result in poorer health and psychosocial outcomes. The primary care home must have the systems

in place and the resources available to build relationships across a spectrum of providers in order to lessen the burden of this transition.

26. Developmental screening and intervention: Development across social, emotional, language and motor domains is influenced by environment and culture. Recognizing these patterns, and the influences upon them, is crucial for the pediatric provider in order to ascertain normal and abnormal development. Optimal outcomes must be promoted via screening with validated instruments and coordinated referral to developmental specialists and Early Intervention. In concert with behavioral specialists, developmental screening and referral is a core function of a primary care home caring for children, and should be a first target for improved coordination and communication.
27. Respecting the developmental stage of the patient and family: The developmental stage of the patient must be respected when organizing care. Children develop within the context of a family, and care environments should be structured to best address developmental differences. For example, a newborn visit, with its emphasis on family functioning and anticipatory guidance, will differ from the confidentiality and autonomy issues an adolescent visit engenders.
28. Ready to learn: Children who have their medical, dental and psychosocial needs met are more likely to succeed once starting formalized education, and the success of meeting this challenge can have a lifelong impact. For this reason a primary care home must emphasize early childhood wellness and family support in order for children under its care to be ready to learn.

Appendix A – Committee Rosters

Patient Centered Primary Care Home - Standards Advisory Committee February 2010 Committee Roster

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Appendix A – Committee Rosters

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Appendix A – Committee Rosters

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Proposed Core Attributes and Standards for Patient Centered Primary Care Homes

Core Attribute: ACCESS TO CARE

“Be there when we need you.”

- Make it easy for us to get care and advice for us and our family members.
- Provide flexible, responsive options for us to get care in a timely way.

Standard: In-Person Access

- Make sure we can quickly and easily get an appointment with someone who knows us and our family.
- Ensure that office visits are well-organized and run on time.

Standard: Telephone and Electronic Access

- Make sure we know what to do if we need or want help when your office is closed.
- Provide multiple ways for us to easily get care or advice outside of office visits.

Standard: Administrative Access

- Respond to our requests for help with refills, paperwork, etc. in the most efficient way possible to meet our needs.

Core Attribute: ACCOUNTABILITY

“Take responsibility for making sure we receive the best possible health care.”

Standard: Performance Improvement

- Work to improve the care and services you provide and ask us for feedback and ideas about what to improve.
- Publically report information about the safety, quality and cost of the care you provide.
- Show us what you are doing to ensure we will get the right care while avoiding unnecessary care.
- Involve us in helping to decide areas for improvement.

Standard: Cost and Utilization

- Keep us informed about the relative costs, benefits and risks of the different options for our care so we can make informed decisions.
- Do not prescribe tests, medications, procedures or referrals that are unnecessary or do not improve our quality of life.

Core Attribute: COMPREHENSIVE WHOLE PERSON CARE

“Provide or help us get the health care, information, and services we need.”

- Help us get prevention services, acute care, care for ongoing problems, and help for mental health conditions or problems with substance or alcohol use.
- Help us understand our health risks and/or conditions and give us tools and support to manage my own care.
- Ask questions about who we are, our strengths and weaknesses, what we do, and where we live, to help care for us.

Standard: Scope of Services

- Provide or coordinate most of the care we need for common problems at your clinic.

APPENDIX B – CORE ATTRIBUTES AND STANDARDS

Core Attribute: CONTINUITY

“Be our partner over time in caring for us.”

- Let us choose our personal clinician.
- Know who we are and remember important information about our health histories, needs and values.
- Help us make well-informed decisions about our health and health care.

Standard: Provider Continuity

- Make sure we can choose a personal clinician and health care team who know and understand us.
- Make sure we can see or talk with our chosen personal clinician or team when we need to.

Standard: Information Continuity

- Make sure that all health professionals caring for us have access to up-to-date and accurate information about our health histories and values.
- Make sure that our personal health information is always protected and kept private.
- Make it easy for us to access our personal health information.

Standard: Geographic Continuity

- Stay involved in our care wherever we go within the health care system, and help us to coordinate our care across places and people.

Core Attribute: COORDINATION AND INTEGRATION

“Help us navigate the health care system to get the care we need in a safe and timely way.”

- Make sure we understand what care or services we need to stay healthy, to manage the problems we have, and where to get them.
- Stay involved in our care and help us avoid unnecessary tests, procedures or interventions.

Standard: Data Management

- Follow our care closely and let us know when tests or checkups are needed.
- Make sure we understand which tests, prevention services, and guidance are recommended to improve our health.

Standard: Care Coordination

- When we need to go to other providers or places for care or services help us coordinate and plan our care without delays and confusion.
- When we need to see a specialist or get a test, help us get what we need at your clinic whenever possible, and stay involved when we get care in other places.
- Make sure we understand the reasons for sending us to a specialist or for a test, prepare us for what to expect, and follow up with us to make sure we understand the results.

Standard: Care Planning

- Help us and our families set goals and plan our care in a way that is understandable and meets our needs.
- Provide us with the information we need to care for our own illness, and help us actively care for ourselves.

APPENDIX B – CORE ATTRIBUTES AND STANDARDS

Core Attribute: 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.”

- Listen to us and our families and caregivers and promote experiences that enhance our independence and control over our health.
- Respect our culture and values and build a relationship with us that is responsive to our needs and preferences.

Standard: Communication

- Communicate in a manner we understand.
- Explain things in ways that make it easy for us to understand and check to be sure we understand.
- Share information in an unbiased way.

Standard: Education and Self-Management Support

- Respect our strengths, our capacity to learn, and engage us as partners in managing our health.
- Help us know the best ways to maintain our health and manage our problems.
- Invite us to set goals for our health and support our efforts to change.

Standard: Experience of Care

- Regularly ask us and our families about our care experience.
- Value our feedback and use this information to improve the way we work together.

APPENDIX C – OVERVIEW OF PROPOSED PATIENT CENTERED PRIMARY CARE HOME MEASURES BY TIER

TIER 1 PRIMARY CARE HOME (PCH) MEASURES	
Access to Care	<p><u>In-Person Access</u>: PCH tracks and reports a standard measure of in-person access to care.</p> <p><u>After Hours Appointments</u>: PCH offers access to in-person care at least 4 hours weekly outside traditional business hours.</p> <p><u>Telephone Advice</u>: PCH provides continuous access to clinical advice by telephone.</p>
Accountability	<p><u>Performance Improvement</u>: PCH tracks at least three performance indicators, one of which is an indicator of a preventive service, and reports goals for improvement.</p>
Comprehensive Whole Person Care	<p><u>Preventive Services</u>: PCH offers or coordinates a determined percentage of recommended preventive services.</p> <p><u>Medical Services</u>: PCH offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including transitions of care; Office-based procedures and diagnostic tests; Patient education and self-management</p> <p><u>Mental Health, Substance Abuse, and Developmental Services</u>: PCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.</p> <p><u>Comprehensive Health Assessment</u>: PCH documents a comprehensive health assessment, and intervention for at least three health risk or developmental promotion behaviors.</p>
Continuity	<p><u>Personal Clinician Assignment</u>: PCH reports the percentage of active patients assigned a personal clinician and team.</p> <p><u>Personal Clinician Continuity</u>: PCH reports patients’ usual provider continuity with their assigned personal clinician or a team member.</p> <p><u>Organization of Clinical Information</u>: PCH maintains an up-to-date health record containing certain elements.</p> <p><u>Specialized Care Settings</u>: PCH has a written agreement with its usual hospital providers.</p>
Coordination and Integration	<p><u>Population Data Management</u>: PCH demonstrates the ability to identify, aggregate, and display data regarding its patient population.</p> <p><u>Population Data Management</u>: PCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients.</p> <p><u>Care Coordination</u>: PCH assigns individual responsibility for care coordination for each patient.</p> <p><u>Test and Result Tracking</u>: PCH tracks ordered tests and notifies patients and clinicians of results.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH either manages hospital or nursing facility care or demonstrates active involvement and coordination of care when its patients receive care in these specialized settings.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates that it can provide all patients with a written care summary.</p> <p><u>End of Life Planning</u>: PCH offers patients the opportunity to complete a POLST or advance directive. PCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.</p>

APPENDIX C – OVERVIEW OF PROPOSED PATIENT CENTERED PRIMARY CARE HOME MEASURES BY TIER

<p>Person and Family Centered Care</p>	<p><u>Roles and Responsibilities</u>: PCH educates patients about PCH and patient roles and responsibilities.</p> <p><u>Language/Cultural Interpretation</u>: PCH communicates with patients in their language of choice.</p> <p><u>Education, Health Promotion, and Self-Management Support</u>: PCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.</p> <p><u>Patient Experience Survey</u>: PCH surveys its patients and families at least annually on their experience of care.</p>
<p>TIER 2 PRIMARY CARE HOME (PCH) MEASURES</p>	
<p>Access to Care</p>	<p><u>In-Person Access</u>: PCH sets a specific goal for improving an in-person access measure and demonstrates improvement.</p>
<p>Accountability</p>	<p><u>Performance Improvement</u>: PCH demonstrates improvement towards its reported goals on at least three performance indicators, one of which is an indicator of a preventive service.</p> <p><u>Public Reporting</u>: PCH publically reports practice-level clinical quality indicators to an external entity.</p> <p><u>Patient and Family Involvement</u>: PCH involves patients and families in quality improvement via quality improvement teams or a practice advisory council.</p>
<p>Comprehensive Whole Person Care</p>	<p><u>Mental Health, Substance Abuse, and Developmental Services</u>: PCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers.</p>
<p>Continuity</p>	<p><u>Personal Clinician Assignment</u>: PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team.</p> <p><u>Personal Clinician Continuity</u>: PCH meets a benchmark or demonstrates improvement in patients’ usual provider continuity with their assigned personal clinician and team.</p> <p><u>Specialized Care Settings</u>: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within one week of hospital discharge.</p>
<p>Coordination and Integration</p>	<p><u>Care Coordination</u>: PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning.</p> <p><u>End of Life Planning</u>: PCH meets a benchmark or demonstrates improvement in the percentage of patients who are offered the opportunity to complete a POLST as appropriate.</p>
<p>Person and Family Centered Care</p>	<p><u>Communication of Patient and PCH Expectations</u>: PCH meets benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities.</p>

APPENDIX C – OVERVIEW OF PROPOSED PATIENT CENTERED PRIMARY CARE HOME MEASURES BY TIER

	<u>Patient Experience Survey</u> : PCH demonstrates using the results of its patient experience survey to improve care.
TIER 3 PRIMARY CARE HOME (PCH) MEASURES	
Access to Care	<u>In-Person Access</u> : PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to in-person care on a patient experience survey.
Accountability	<u>Clinical Quality Improvement</u> : PCH demonstrates improvement in a certain number of clinical quality indicators, including preventive services. PCHs achieving a benchmark level of performance on a given indicator would be required to maintain excellent performance, but not demonstrate continued improvement. <u>Patient and Family Involvement</u> : PCH obtains data or feedback from patients and families regarding experience or focus of quality improvement efforts.
Comprehensive Whole Person Care	<u>Mental Health, Substance Abuse, and Developmental Services</u> : PCH documents actual or virtual co-location with specialty mental health, substance abuse, or developmental providers.
Continuity	<u>Clinical Information Exchange</u> : PCH shares clinical information electronically in real time with other providers and systems.
Coordination and Integration	<u>Electronic Health Record</u> : PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules. <u>Referral and Specialty Care Coordination</u> : PCH tracks referrals and coordinates care where appropriate for community settings outside the PCH (such as dental, educational, social service, foster care, public health, or long term care settings). <u>Comprehensive Care Planning</u> : PCH measures and demonstrates improvement in the percentage of high risk patients or patients with special health care needs who have a written care plan that has been developed and reviewed with the patient and/or caregivers in the past year.
Person and Family Centered Care	<u>Patient Experience Survey</u> : PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics.
ADDITIONAL PRIMARY CARE HOME (PCH) MEASURES	
Access to Care	<u>In-Person Access</u> : PCH offers access to in-person care 8 or more hours weekly outside traditional business hours. <u>Telephone Advice</u> : Telephone encounters (including after hours) are documented in the patient’s medical record. <u>Telephone Advice</u> : PCH tracks and improves the time required to resolve telephone requests for clinical advice. <u>Electronic Access</u> : PCH provides at least one option for electronic access, such as e-mail or a “web portal.” <u>Prescription Refills</u> : PCH tracks the percentage of prescription refill requests completed within two business days and meets a benchmark or demonstrates improvement in this percentage over time.

APPENDIX C – OVERVIEW OF PROPOSED PATIENT CENTERED PRIMARY CARE HOME MEASURES BY TIER

	<u>Administrative Requests</u> : PCH demonstrates a mechanism to track administrative paperwork requests and demonstrates improvement in the percentage met promptly, in accordance with the acuity of the request.
Accountability	<u>Ambulatory Sensitive Utilization</u> : PCH demonstrates risk-adjusted reductions in utilization measures or excellent performance across its patient population according to prior performance or a risk-adjusted community standard.
Comprehensive Whole Person Care	<u>Health Promotion</u> : PCH documents improvement in its rates of intervention for a given health risk or developmental promotion behavior. <u>Health Promotion</u> : PCH documents reduction of the percentage of its patients or families with a given health risk behavior over time.
Continuity	<u>Clinical Information Exchange</u> : PCH transmits data to patients’ electronic personal health records or provides an electronic means for patients to access their personal health information in real time. <u>Specialized Care Settings</u> : PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department.
Coordination and Integration	<u>Population Data Management</u> : PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients. <u>Care Coordination</u> : PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions. <u>Test and Result Tracking</u> : PCH demonstrates tracking planned or indicated tests and generating reminders for patients and/or caregivers and clinicians. <u>Referral and Specialty Care Coordination</u> : PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receiving ongoing specialty care outside the PCH.
Person and Family Centered Care	<u>Communication</u> : PCH makes written material available in the patient or family’s language of choice and at an appropriate literacy level. <u>Communication</u> : PCH ensures communication with patients and families is culturally appropriate. <u>Education and Self-Management Support</u> : PCH assesses patient or family activation or readiness to change (as appropriate) and uses this information to improve patient or family education, health promotion and prevention, and self-management. <u>Education and Self-Management Support</u> : PCH tracks and improves the percentage of patients with a particular chronic condition who have been offered education or self-management support. <u>Education and Self-Management Support</u> : PCH demonstrates active follow up with patients regarding their self-management goals.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Proposed Measures for Patient Centered Primary Care Homes

Tier 1, 2 and 3 Measures: Important primary care home (PCH) elements. Increasing numbers of these elements should be required for recognition as a basic, intermediate or advanced primary care home.

Additional Measures: Additional primary care home elements that represent “value added” activities and services. These measures should not be required for recognition as a PCH, but clinics meeting additional measures should be rewarded with enhanced payment.

CORE ATTRIBUTE: ACCESS TO CARE
<p><i>“Be there when we need you.”</i></p> <ul style="list-style-type: none">• Make it easy for us to get care and advice for us and our family members.• Provide flexible, responsive options for us to get care in a timely way.
<p>Standard: In-Person Access</p> <ul style="list-style-type: none">• Make sure we can quickly and easily get an appointment with someone who knows us and our family.• Ensure that office visits are well-organized and run on time.
<p>Access Measure 1: In-Person Access PCH tracks and improves in-person access to care and patient satisfaction with in-person access to care.</p> <p>Tier 1: PCH tracks and reports a standard measure of in-person access to care.</p> <p>Tier 2: PCH sets a specific goal for improving an in-person access measure and demonstrates improvement.</p> <p>Tier 3: PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to in-person care on a patient experience survey.</p>
<p>Access Measure 2: After Hours Access PCH offers access to in-person care outside of traditional business hours.</p> <p>Tier 1: PCH offers access to in-person care at least 4 hours weekly outside traditional business hours.</p> <p>Additional Measure: PCH offers access to in-person care 8 or more hours weekly outside traditional business hours.</p>
<p>Standard: Telephone and Electronic Access</p> <ul style="list-style-type: none">• Make sure we know what to do if we need or want help when your office is closed.• Provide multiple ways for us to easily get care or advice outside of office visits.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

<p>Access Measure 3: Telephone Access PCH provides telephone access to clinical advice 24 hours a day and tracks and improves telephone care.</p> <p>Tier 1: PCH provides continuous access to clinical advice by telephone.</p> <p>Additional Measure: Telephone encounters (including after hours encounters) are documented in the patient’s medical record.</p> <p>Additional Measure: PCH tracks and improves the time required to resolve telephone requests for clinical advice.</p>
<p>Access Measure 4: Electronic Access PCH provides an option for patients and caregivers to access care, clinical advice and test results in an electronic format.</p> <p>Additional Measure: PCH provides at least one option for electronic access, such as secure e-mail or a secure “web portal” (See also Continuity Measure #4)</p>
<p>Standard: Administrative Access</p> <ul style="list-style-type: none">• Respond to our requests for help with refills, paperwork, etc. in the most efficient way possible to meet our needs.
<p>Access Measure 5: Prescription Refills PCH responds to requests for prescription refills promptly, in accordance with the acuity of the condition treated.</p> <p>Additional Measure: PCH tracks the percentage of prescription refill requests completed within two business days and meets a benchmark or demonstrates improvement in this percentage over time.</p>
<p>Access Measure 6: Health Record Paperwork PCH responds to requests for administrative paperwork promptly, in accordance with the acuity of the nature of the request. (examples include immunization record or FMLA requests).</p> <p>Additional Measure: PCH demonstrates a mechanism to track administrative paperwork requests and demonstrates improvement in the percentage met promptly, in accordance with the acuity of the request.</p>
<p>CORE ATTRIBUTE: ACCOUNTABILITY</p>
<p><i>“Take responsibility for making sure we receive the best possible health care.”</i></p>

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

<p>Standard: Performance Improvement</p> <ul style="list-style-type: none">• Work to improve the care and services you provide and ask us for feedback and ideas about what to improve.• Publically report information about the safety, quality and cost of the care you provide.• Show us what you are doing to ensure we will get the right care while avoiding unnecessary care.• Involve us in helping to decide areas for improvement.
<p>Accountability Measure 1: Performance Improvement PCH measures its own performance, with an emphasis on preventive services, sets goals, and improves its care over time.</p> <p>Tier 1: PCH tracks at least three performance indicators, one of which is an indicator of a preventive service, and reports goals for improvement.</p> <p>Tier 2: PCH demonstrates improvement towards its reported goals on at least three performance indicators, one of which is an indicator of a preventive service.</p> <p>Performance indicators could be defined by the PCH across a range of domains, such as clinical processes, clinical outcomes, evaluating patient and family education efforts and materials, or patient or staff satisfaction (See also Access Measures #1,3&5; Comprehensive Measure #4, Continuity Measures #1,2&5; Coordination Measures #1,4,5,6&7; and Person-Centered Measures #1,3&4).</p>
<p>Accountability Measure 2: Clinical Quality Improvement PCH improves clinical quality indicators, with an emphasis on indicators of preventive services, in its patient population.</p> <p>Tier 3: PCH demonstrates improvement in a certain number of clinical quality indicators.</p> <p>PCHs should have the ability to select quality measures most relevant to their patient population from a pre-established statewide set of nationally accepted quality measures.</p>
<p>Accountability Measure 3: Public Reporting PCH participates in a program of voluntary public reporting of practice-level clinical quality.</p> <p>Tier 2: PCH publically reports practice-level clinical quality indicators to an external entity.</p> <p>Examples may include a health plan, Medicare or Medicaid, the State, or the Oregon Quality Corporation.</p>
<p>Accountability Measure 4: Patient and Family Involvement PCH involves patients and families in developing and evaluating performance and clinical quality improvement.</p> <p>Tier 2: PCH involves patients and families in quality improvement via quality improvement teams or a practice advisory council.</p> <p>Tier 3: PCH obtains data or feedback from patients and families regarding experience or focus of quality improvement efforts.</p>

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Standard: Cost and Utilization

- Keep us informed about the relative costs, benefits and risks of the different options for our care so we can make informed decisions.
- Do not prescribe tests, medications, procedures or referrals that are unnecessary or do not improve our quality of life.

Accountability Measure 5: Ambulatory Sensitive Utilization

PCH manages patient care effectively, thereby reducing unnecessary or preventable utilization of specific services that increase costs without improving health.

Additional Measure: PCH demonstrates risk-adjusted reductions in utilization measures or excellent performance across its patient population according to prior performance or a risk-adjusted community standard.

PCHs should have the ability to select utilization measures most relevant to their patient population from a pre-established set of utilization measures. Examples of utilization measures could include: ER visits (total or among high users), re-admissions, admissions for ambulatory sensitive conditions, hospital bed days/1000 patients, high cost imaging, duplicated tests, or generic medication prescribing.

CORE ATTRIBUTE: COMPREHENSIVE WHOLE PERSON CARE

“Provide or help us get the health care, information, and services we need.”

- *Help us get prevention services, acute care, care for ongoing problems, and help for mental health conditions, developmental conditions, or problems with substance or alcohol use.*
- *Help us understand our health risks and/or conditions and give us tools and support to manage our own care.*
- *Ask questions about who we are, our strengths and weaknesses, what we do, and where we live to help care for us.*

Standard: Scope of Services

- Provide or coordinate most of the care we need for common problems at your clinic.

Comprehensive Measure 1: Preventive Services

PCH offers or coordinates age and gender appropriate preventive services.

Tier 1: PCH offers or coordinates a determined percentage of recommended preventive services.

PCH offers most age and gender appropriate preventive services, potentially from the following: USPSTF recommended services, ACIP recommended vaccinations and developmental screening in infancy and early childhood.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Comprehensive Measure 2: Medical Services

PCH offers or coordinates a broad range of medical services to meet the care needs of its patient population within the PCH as often as possible.

Tier 1: PCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including transitions of care; Office-based procedures and diagnostic tests; Patient education and self-management.

Comprehensive Measure 3: Mental Health, Substance Abuse, and Developmental Services

PCH routinely offers or coordinates care for mental health, substance use, or developmental disorders.

Tier 1: PCH documents its screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.

Tier 2: PCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers.

Tier 3: PCH documents actual or virtual co-location with specialty mental health, substance abuse, or developmental providers.

Practices could be exempt from Tier 2 and 3 measures if a shortage of mental health, developmental or substance abuse providers or services exists within their geographic area or for their patient population. In addition screening and collaboration strategies should reflect the practice's patient population.

Comprehensive Measure 4: Comprehensive Health Assessment and Intervention

The PCH routinely assesses common health behaviors within the family unit and offers interventions to support healthy behaviors and environments, including risk behavior reduction, safety and anticipatory guidance, and developmental screening and promotion as appropriate.

Tier 1: PCH documents comprehensive health assessment and intervention for at least three health risk or developmental promotion behaviors.

Additional Measure: PCH documents improvement in its rates of intervention for a given health risk or developmental promotion behavior.

Additional Measure: PCH documents reduction of the percentage of its patients or families with a given health risk behavior over time.

CORE ATTRIBUTE: CONTINUITY

“Be our partner over time in caring for us.”

- Let us choose our personal clinician.
- Know who we are and remember important information about our health histories, needs and values.
- Help us make well-informed decisions about our health and health care.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

<p>Standard: Provider Continuity</p> <ul style="list-style-type: none">• Make sure we can choose a personal clinician and health care team who know and understand us.• Make sure we can see or talk with our chosen personal clinician or team when we need to.
<p>Continuity Measure 1: Personal Clinician Assignment</p> <p>The PCH assigns individuals to a personal clinician and primary care team using individual and family choice as the primary guiding principle.</p> <p>Tier 1: PCH reports the percentage of active patients assigned a personal clinician and team.</p> <p>Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team.</p>
<p>Continuity Measure 2: Personal Clinician Continuity</p> <p>The PCH tracks and seeks to improve patients’ continuity with their chosen personal clinician and primary care team.</p> <p>Tier 1: PCH reports patients’ usual provider continuity with their assigned personal clinician or a team member.</p> <p>Tier 2: PCH meets a benchmark or demonstrates improvement in patients’ usual provider continuity with their assigned personal clinician and team.</p>
<p>Standard: Information Continuity</p> <ul style="list-style-type: none">• Make sure that all health professionals caring for us have access to up-to-date and accurate information about our health histories and values.• Make sure that our personal health information is always protected and kept private.• Make it easy for us to access our personal health information.
<p>Continuity Measure 3: Organization of Clinical Information</p> <p>PCH maintains up-to-date and accurate records and organizes clinical information in a way that is easily shared with and understandable by health care professionals inside and outside the PCH. Maintaining accurate and up-to-date health records is an essential prerequisite for care coordination and care planning (See Coordination Measure #2 and #6).</p> <p>Tier 1: PCH 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.</p>

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Continuity Measure 4: Clinical Information Exchange

PCH demonstrates timely and confidential exchange of important clinical information with hospitals and consultants and provides patients with electronic access to their health information.

Tier 3: PCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).

Additional Measure: PCH demonstrates that it transmits data to patients’ electronic personal health records or provides an electronic means for patients or caregivers to access their personal health information in real time (See also Access Measure #4).

Standard: Geographic Continuity

- Stay involved in our care wherever we go within the health care system, and help us to coordinate our care across places and people.

Continuity Measure 5: Specialized Care Settings

PCH tracks when its patients are cared for in specialized care settings (e.g. hospital, nursing facility, or other residential treatment) and is actively involved during and after care in these settings (See also Coordination Measure #5).

Tier 1: PCH has a written agreement with its usual hospital providers or directly provides routine hospital care.

Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge.

Additional Measure: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department.

CORE ATTRIBUTE: COORDINATION AND INTEGRATION

“Help us navigate the health care system to get the care we need in a safe and timely way.”

- Make sure we understand what care or services we need to stay healthy, to manage the problems we have, and where to get them.
- Stay involved in our care and help us avoid unnecessary tests, procedures or interventions.

Standard: Data Management

- Follow our care closely and let us know when tests or checkups are needed.
- Make sure we understand which tests, preventive services, and guidance are recommended to improve our health.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Coordination Measure 1: Population Data Management

PCH uses a system to organize, track and improve the care of its patient population.

Tier 1: PCH demonstrates the ability to identify, aggregate, and display data regarding its patient population.

Tier 1: PCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients.

Additional Measure: PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients.

PCHs may choose to create lists or registries of sub-populations based on a variety of conditions (e.g. diabetes or pregnancy) or demographic characteristics (e.g. children < age 1 or women).

Proactive management could be demonstrated through the use of a list or registry to track and improve care delivery through strategies such as care protocols and patient or clinician reminders.

Coordination Measure 2: Electronic Health Record

PCH has an electronic health record (EHR) and uses this tool to improve patient care.

Tier 3: PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules.

Standard: Care Coordination

- When we need to go to other providers or places for care or services, help us coordinate and plan our care without delays and confusion.
- When we need to see a specialist or get a test, help us get what we need at your clinic whenever possible, and stay involved when we get care in other places.
- Make sure we understand the reasons for sending us to a specialist or for a test, prepare us for what to expect, and follow up with us to make sure we understand the results.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Coordination Measure 3: Care Coordination

PCH assigns individual responsibility for care coordination for each patient to a member of the health care team.

Tier 1: PCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care.

Tier 2: PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.

Additional Measure: PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions.

Care coordination functions might include the following:

- coordination of care received outside the PCH and in specialized care settings
- tracking of indicated care and tests
- self management support and education
- motivational interviewing and coaching on behavior change

Coordination Measure 4: Test and Result Tracking

PCH tracks laboratory and imaging tests and follows up on results.

Tier 1: PCH demonstrates tracking of 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.

Additional Measure: PCH demonstrates tracking planned or indicated tests and generating reminders for patients and/or caregivers and clinicians.

Coordination Measure 5: Referral and Specialty Care Coordination

PCH tracks and coordinates the care its patients receive outside the PCH.

Tier 1: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.

Tier 1: PCH either manages hospital or skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings.

Tier 3: PCH tracks referrals and coordinates care where appropriate for community settings outside the PCH (such as dental, educational, social service, foster care, public health, or long term care settings).

Additional Measure: PCH demonstrates collaborative care planning with other health care professionals and entities and patients and their families when patients receive ongoing specialty care outside the PCH.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Standard: Care Planning

- Help us and our families set goals and plan our care in a way that is understandable and meets our needs.
- Provide us with the information we need to care for our own illness, and help us actively care for ourselves.

Coordination Measure 6: Comprehensive Care Planning

PCH plans and coordinates care for its patients at the level of intensity indicated by each individual’s needs.

Tier 1: PCH demonstrates that it can provide all patients with a written care summary, developed in concert with the patient or family, that includes the following:

- current problem list
- medication list and allergies
- indicated preventive care including immunization status
- goals of preventive and chronic illness care

Tier 2: PCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCH demonstrates it can provide these patients and families with a written care plan that includes the following:

- self management goals
- goals of preventive and chronic illness care
- action plan for exacerbations of chronic illness (when appropriate)
- end of life care plans (when appropriate)

Tier 3: PCH measures and demonstrates improvement in the percentage of high risk patients or patients with special health care needs who have a written care plan that has been developed and reviewed with the patient and/or caregivers in the past year.

PCH practices should have the ability to define high-risk individuals within their patient population and target care planning activities to patients most likely to benefit, such as individuals at risk of a chronic illness exacerbation.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Coordination Measure 7: End of Life Planning

The PCH offers or coordinates end of life planning and counseling to patients and families who may benefit from these services.

Tier 1: PCH documents offering or coordinating the opportunity for patients or families to complete a POLST form or advance directive (when appropriate) and attests to submitting completed POLST forms to the Oregon POLST registry (unless patients opt out).

Tier 1: PCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

Tier 2: PCH meets a benchmark or demonstrates improvement in the percentage of patients who are offered the opportunity to complete a POLST as appropriate.

Core Attribute: 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.”

- Listen to us, our families and caregivers, and promote experiences that enhance our independence and control over our health.
- Respect our culture and values and build a relationship with us that is responsive to our needs and preferences.

Standard: Communication

- Communicate in a manner we understand.
- Explain things in ways that make it easy for us to understand and check to be sure we understand.
- Share information in an unbiased way.

Family Centered Care Measure 1: Communication of Roles and Responsibilities

PCH communicates with its patients and families about the PCH and patient and family roles and responsibilities.

Tier 1: PCH has a written document or other educational materials that outline PCH and patient/family roles and responsibilities, and documents that this information has been communicated to each patient or family at the onset of the care relationship.

Tier 2: PCH meets a benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities.

Educational materials should contain at least the following information: options for accessing care, names of primary care team members, information on care planning and care coordination and information on patient/family responsibilities.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Family Centered Care Measure 2: Language/Cultural Interpretation

PCH communicates with patients and families in a manner they understand.

Tier 1: PCH documents the offer and/or use of either providers who speak a patient and family’s language or time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.

Additional Measure: PCH makes written material available in the patient or family’s language of choice and at an appropriate literacy level.

Additional Measure: PCH ensures communication with patients and families is culturally appropriate.

Standard: Education and Self-Management Support

- Respect our strengths, our capacity to learn, and engage us as partners in managing our health.
- Help us know the best ways to maintain our health and manage our problems.
- Invite us to set goals for our health and support our efforts to change.

Family Centered Care Measure 3: Education, Health Promotion, and Self-Management Support

PCH offers education, health promotion and prevention, and self-management support to patients and their families and caregivers who would benefit from such services.

Tier 1: PCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources.

Additional Measure: PCH assesses patients’ or family’s activation or readiness to change (as appropriate) and uses this information to improve patient or family education, health promotion and prevention, and self-management.

Additional Measure: PCH tracks and improves the percentage of patients with a particular chronic condition who have been offered education or self management support, including referral to community programs outside the PCH.

Additional Measure: PCH demonstrates active follow up with patients regarding their self-management goals.

Examples of education, health promotion, and self-management support might include:

- Information about basic diagnosis, prognosis, exacerbations and/or treatment of conditions
- Global health assessment and promotion of healthy behaviors
- Developmental screening, guidance and support
- Strategies for self-management of chronic conditions and patient and family empowerment to change the course of illness and improve health
- Resources for further education and support

Standard: Experience of Care

- Regularly ask us and our families about our care experience.
- Value our feedback and use this information to improve the way we work together.

APPENDIX D – PROPOSED MEASURES FOR PATIENT CENTERED PRIMARY CARE HOMES

Family Centered Care Measure 4: Patient Experience Survey

PCH regularly surveys its patients and families on their experience of care and uses this information to improve care.

Tier 1: PCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family centered care.

Tier 2: PCH demonstrates using the results of its patient experience survey to improve care.

Tier 3: PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics.

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