Oregon Health Authority
Patient-Centered Primary Care Home Program
2017 Recognition Criteria
Technical Specifications and Reporting Guide

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Version 1

www.PrimaryCareHome.oregon.gov

Email: PCPCH@state.or.us

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Oregon Patient-Centered Primary Care Home 2017 Recognition Criteria
Technical Specifications and Reporting Guide (TA Guide)

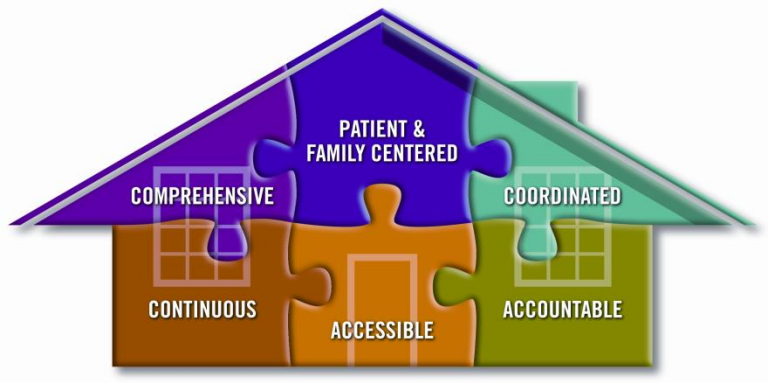
Introduction

Thank you for your interest in Patient-Centered Primary Care Home (PCPCH) recognition for your practice. As a recognized primary care home, your practice can be part of Oregon's vision for better health, better care, and lower costs for all Oregonians.

The Oregon Legislature established the Patient-Centered Primary Care Home Program in 2009. The program works with stakeholders across Oregon to set the standards for what high-quality, patient-centered primary care looks like. The program also identifies primary care homes, promotes their development, and encourages Oregonians to seek care through recognized primary care homes.

Patient-Centered Primary Care Homes are health care clinics that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care. At its heart, this model of care fosters strong relationships with patients and their families to better care for the whole person. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness, and managing chronic conditions.

The Core Attributes of Primary Care Homes



Key standards for recognition

- **Accessible:** Care is available when patients need it.
- **Accountable:** Clinics take responsibility for the population and community they serve and provide quality, evidence-based care.
- **Comprehensive:** Patients get the care, information and services they need to stay healthy.
- **Continuous:** Providers know their patients and work with them to improve their health over time.
- **Coordinated:** Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- **Patient & Family Centered:** Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

This document represents the most recent revisions to the Patient-Centered Primary Care Home recognition criteria based on the recommendations of the PCPCH Standards Advisory Committee and input from various stakeholders across Oregon. To learn more about the PCPCH Standards Advisory Committee, please visit the program website at www.PrimaryCareHome.oregon.gov.

The 2017 PCPCH recognition criteria are effective on January 1, 2017. Any clinics applying for PCPCH recognition on or after January 1, 2017 must meet the criteria contained in this document.

How to Use the TA Guide

The information and technical specifications in this guide are critical for clinics seeking recognition as Patient-Centered Primary Care Homes. This guide includes narrative descriptions of the intent of each PCPCH standard as well as specific definitions, measurement criteria, and example strategies that clinics might employ to meet the intent of each standard. The information provided in this guide is not intended as an all-inclusive list of the strategies clinics could employ to meet each standard.

For standards requiring attestation only, this guide describes the information a clinic should collect and retain for documentation purposes, even though data submission is not required at the time an application is submitted. For standards requiring additional data submission, this guide describes how clinics should collect, calculate, and submit this data. Protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations, must be removed or blocked out from documents submitted, including patient identifiers.

Best Practice Notes contain helpful information and suggestions for clinics implementing PCPCH criteria. The information contained in the Best Practice Notes are not technically required for PCPCH recognition or verification purposes, but clinics striving to go beyond the checklist and implement best practice approaches will find these suggestions helpful.

PCPCH is a Journey, Not a Destination

The PCPCH is Oregon's version of the "medical home" which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. The PCPCH model represents a road map for providing evidence-based, high-quality comprehensive primary care services. While your clinic may "check the box" for meeting certain PCPCH standards, you are encouraged to truly

transform the way things are done and implement a "patient-centered" approach to all activities. As described by the Patient-Centered Primary Care Collaborative,[1]

> *The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.*

Clinics are also encouraged to think outside the walls of their clinic, utilizing a robust health care neighborhood to support the primary care home and their patients. Primary care homes are encouraged to partner with local public health agencies and community organizations to educate and support patients, identify community health priorities, and develop plans to improve the overall health of their communities.

To ensure your primary care home is truly patient-centered, your clinic should strive to move beyond the checklist to implement services that are tailored to the specific needs of your patients. To list just a few examples, you could implement plain language communications,[2] ensuring that services are culturally competent and abide by universal precautions for health literacy, or partner with a local organization to have a food truck at your clinic that offers fresh fruits and vegetables, or offer yoga or diabetes walking classes at the clinic. As your patients' primary care home, you can continuously work to ensure they have what they need for better health and better care. The PCPCH Program is here to support and encourage your clinic to begin, or continue, this journey today.

PCPCH Eligibility

Any type of health care clinic that provides comprehensive primary care services and meets the PCPCH criteria for recognition is eligible to apply. Clinics must be able to report on 12 months of data for their quality and continuity measures, therefore, a clinic must be open for business and have access to at least 12 months of data prior to submitting an application for recognition. In

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[1] Patient-Centered Primary Care Collaborative http://www.pcpcc.org/about/medical-home

[2] http://www.plainlanguage.gov/

certain circumstances, exceptions may be made. Please contact the program for more information.

Clinics applying for PCPCH recognition must thoroughly review this guide, including technical specifications, prior to submitting an application. The technical specifications describe each standard in more detail, including what documentation the clinic must have to support their attestation. Any standards that a clinic attests to or submits data for must be inclusive of and applicable to all clinicians and patient populations at the clinic.

Important Note: *Clinics must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted.*

If an organization operates multiple practice sites, a separate application must be submitted for each site, with data specific to that clinic. If all practice sites applying for recognition operate under the same policies and procedures and share the same electronic health record to document patient care, then some questions will be answered the same for each practice site. However, standards that require data submission must be calculated and submitted with data specific to each practice site. If you have any questions about your clinic's eligibility, please contact us at PCPCH@state.or.us.

Scoring Framework

Clinics can be recognized at five different levels, or tiers, depending on the criteria they meet. There are 11 "must-pass" criteria that every clinic must meet in order to be recognized as a primary care home at any level. The other criteria are worth varying amounts of points, and the total points accumulated by a clinic determines their overall tier of PCPCH recognition.

Except for the 11 must-pass measures, each measure is assigned a point value. Must-pass and 5 point measures focus on foundational PCPCH elements that should be achievable by most clinics in Oregon with significant effort, but without significant financial outlay. Measures worth 10 or 15 points reflect intermediate and advanced functions.

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

5 STAR Designation

Tier 5 in the PCPCH model is a unique designation called 5 STAR. This designation distinguishes exemplary clinics that have implemented advanced transformative processes into their workflow using the PCPCH model framework and recommended best practices.

5 STAR designated practices must meet the following criteria:

- Be recognized as a PCPCH Tier 4 under the 2017 PCPCH Standards
- Attest to 255 points or more on the clinic's most recently submitted PCPCH application
- Meet 11 or more of the 13 specified measured listed in the table on page 10.
- Receive a site visit to verify they are meeting all PCPCH standards attested to. The designation will not be awarded on attestation only.

PCPCH Application Process

To apply for PCPCH recognition, please take the following steps:

1. **Read the TA Guide** - Read this guide and have a clear understanding of the intent behind each standard to determine if the practice has services, policies, and procedures in place to meet the criteria.

2. **Self-Assessment Form** - Visit the PCPCH Program website at www.PrimaryCareHome.oregon.gov and fill out the self-assessment tool, using the information in this guide to help you determine which standards you meet. This tool helps you answer questions and gather required data before you submit an application. It also helps you estimate which tier of recognition you could qualify for based on what standards you meet.

3. **Submit your Application** - Visit the program website Become Recognized page at www.PrimaryCareHome.oregon.gov and log into the PCPCH application system. Complete and submit the electronic application. Each practice site must submit a separate application. After your application is submitted with all required data, OHA staff will review the application and notify you of the results in writing within 60 days.

What to Expect after Your Clinic is Recognized as a Patient-Centered Primary Care Home

Recognition Renewal Requirements

Your clinic's recognition as a primary care home expires 2 years from your effective date of recognition. After that time, you will be required to submit a renewal application in order to maintain your clinic's tier level and status as a recognized primary care home. If your clinic would like the opportunity to increase your tier level or overall score, you can submit a renewal application once every 6 months.

Incentives for recognized clinics

Oregon is working toward a system that rewards high quality, efficient care that results in better health outcomes. To meet that goal, OHA is working with public and private payers across Oregon to pursue innovative payment methods that align with the PCPCH model of care. This will help primary care homes focus on what's really important – health.

After your clinic is recognized as a primary care home, there may payment incentives available from the health plans that your clinic contracts with. For more information please visit the PCPCH program website Payment Incentives page.

On-Site Verification

PCPCH Program staff will conduct a site visits to recognized PCPCHs. The purpose of the on-site verification visit is threefold:

1. Verification that the clinic practice and patient experience accurately reflects the standards and measures attested to when the clinic was recognized as a PCPCH;
2. Assessment of the care delivery and team transformation process in the clinic to understand how the intent of the patient-centered model of care is integrated into the services the primary care home provides; and
3. Collaboration to identify clinic needs, barriers to implementation and areas of improvement needed to help practices successfully implement PCPCH standards. The site visit team helps practices establish improvement plans, and connects practices with technical assistance through resources including the Patient-Centered Primary Care Institute.

Recognized clinics are randomly selected for a site verification visit. This TA Guide explains what documentation the clinic must have to support its attestation. The TA Guide also describes how clinics should collect and calculate any required data. As your clinic prepares to submit a PCPCH application, it is strongly recommended you prepare a binder of documentation to support the application attestation. A documentation binder will be required for each clinic selected for a site visit. If your clinic is chosen for a verification site visit, we will contact you at least 30 days prior to the intended site visit date and work with you as your clinic prepares for the visit.

PCPCH Program Updates

PCPCH Program updates and other relevant information about your clinic's recognition is communicated by email. Please visit www.govdelivery.com to sign up to receive PCPCH Program updates.

Changes at your clinic

You are required to inform the PCPCH Program of any significant changes at your clinic. New ownership, clinic relocation, change in clinic contact information, clinic closure, loss of key clinical staff, or other changes should be reported to PCPCH@state.or.us

Technical Assistance and Resources

The Patient-Centered Primary Care Institute connects practices in all stages of primary care home transformation - from those looking to begin the process to those already recognized as primary care homes - to a broad array of technical assistance and resources. Visit the Institute website where you can search for tools and resources by PCPCH standard or topic area, and learn about upcoming training opportunities. There are also interactive online learning modules for the PCPCH Program 2017 Recognition Standards which can be used as a companion to this TA guide to help facilitate better understanding, and to connect you with concrete resources to help meet the different standards and measures. These are free and count for CME credit (for physicians) and CE credit (for nurses). Learn more at www.pcpci.org.

NCQA and Oregon PCPCH Recognition

Some practices in Oregon are recognized as a Patient Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). While this model is not identical to the Oregon PCPCH model, there are areas of commonality. A clinic that is already PCMH NCQA-recognized has the option to bypass attesting to some of the PCPCH standards. Depending on the version of PCMH NCQA recognition that was achieved, clinics seeking PCPCH recognition must attest to and submit additional information as outlined in the tables below. OHA will recognize PCMH NCQA clinics at the same level that NCQA has recognized the clinic. For example, a PCMH NCQA Level 2 would be recognized as a PCPCH Tier 2. PCMH NCQA recognized clinics that choose to bypass attesting to some PCPCH standards must also submit documentation of their NCQA recognition by email to PCPCH@state.or.us prior to OHA recognition.

A clinic that is PCMH NCQA recognized has the option to submit an entire PCPCH application. The clinic will be recognized according to the scoring system outlined in this guide. PCMH NCQA recognized clinics are required to submit an entire PCPCH application to be considered for Tier 4 or 5 STAR.

Oregon PCPCH Program and 2011 and 2014 NCQA Recognition Requirements
For practices that are recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home

Requirement	Oregon PCPCH Tier Recognition				
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5 (5 STAR)**
2011 or 2014 Level 1 NCQA PCMH Recognition	Attests and provides evidence of recognition to OHA	N/A	N/A	N/A	N/A
2011 or 2014 Level 2 NCQA Recognition	N/A	Attests and provides evidence of recognition to OHA	N/A	N/A	N/A
2011 or 2014 Level 3 NCQA Recognition	N/A	N/A	Attests and provides evidence of recognition to OHA	N/A	N/A
PCPCH Performance & Clinical Quality Standard 2.A	**2.A.0** PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures	**2.A.2** PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures	**2.A.3** PCPCH tracks, reports to the OHA and meets benchmarks on two measures from core set and one measure from the menu set of PCPCH Quality Measures	N/A	N/A
PCPCH Coordination and Integration Standard 5.F	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0	Attests to meeting must pass measure 5.F.0
Submission of PCPCH recognition application to Oregon Health Authority	Optional	Optional	Optional	Attests to PCPCH measures as outlined in this document.	Attests to PCPCH measures as outlined in this document.

The 11 Must-Pass Criteria for PCPCH Recognition

STANDARD	MEASURE
1.C Telephone and Electronic Access	1.C.0 - PCPCH provides continuous access to clinical advice by telephone.
2.A Performance & Clinical Quality	2.A.0 - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.
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.
3.C Behavioral Health Services	3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources.
4.A Personal Clinician Assignment	4.A.0- PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)
4.B Personal Clinician Continuity	4.B.0 - PCPCH reports the percent of patient visits with assigned clinician or team. (D)
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.
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.
5.F End of Life Planning	5.F.0 - PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.
6.ALanguage/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
6.C Experience of Care	6.C.0 - PCPCH surveys a sample of its patients and families 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.

(D) – Data submission required with application.

5 STAR Designation Criteria Measures

1.B.1 After Hours Access	PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
2.D.3 Quality Improvement	PCPCH has a documented clinic-wide improvement strategy with performance goals derived from patient, family, caregiver and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.
3.C.2 Referral Process or Co-location with Mental Health, Substance Abuse or Developmental Providers	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
3.C.3 Integrated behavioral health services	PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.
4.B.3 Personal Clinician Continuity	PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team (80%).
5.C.1 Responsibility for Care Coordination	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 responsible for coordinating his or her care.
5.C.2 Coordination of Care	PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.
5.C.3 Individualized Care Plan	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.
5.E.1Referral Tracking For Specialty Care	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.
5.E.2 Coordination with Specialty Care	PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).
5.E.3 Cooperation with Community Service Providers	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.
6.A.1 Language/Cultural Interpretation	PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.
6.C.2 <u>or</u> 6.C.3 Experience of Care	6.C.2 -PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process. 6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process, and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.

Questions?

We are here to help. Please contact the Patient-Centered Primary Care Home Program team at PCPCH@state.or.us or 503-373-7768 if you have any questions about the application process or the standards for recognition.

Core Attribute 1: ACCESS TO CARE
Standard 1.A – In-Person Access

Measures:

1.A.1 - PCPCH surveys a sample of its population on satisfaction with in-person access to care. (5 points)

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. (10 points)

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. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting any of these measures.

Intent - "First contact" access to both routine and urgent care is a core feature of primary care. Primary care homes should have the ability to gather patient feedback to understand and improve upon patients, caregivers, and families' access to in-person care.

Documentation Required – At a verification site visit, clinics should be able to produce documentation to support the attestation including the survey form used and all data collected from the last survey administered (number of responses, dates conducted, and results).

Specifications -

To meet 1.A.1, clinics must follow these procedures:

- Clinics must conduct a patient experience survey to collect feedback from patients, caregivers, and families regarding their experience with in-person access to care.
- Patient survey questions must assess patients, caregivers, and families' experience getting in-person appointments in the practice. The CAHPS survey questions (below) are recommended but not required.
- Clinics must obtain survey results for a minimum of 25 patients per provider, and must include all completed survey results in reported data.

- Patients must be included from all providers who have an assigned patient panel at the

clinic.

- Clinics should survey patients in a way that is both random and anonymous. Examples of an appropriate survey methodology could include distributing a patient survey to every 5th patient or surveying all patients with appointments during a specific time period.
- Clinics may directly survey patients or conduct a patient survey through a 3rd party vendor (e.g. Press Ganey, National Research Corporation, etc.).
- Surveys may be collected on paper, via telephone or electronically.
- It is recommended that survey tools be linguistically and culturally appropriate, available in multiple languages and alternative formats, and take literacy into account based on the clinic's patient population.
- 50% or more of the survey questions must be answered for the survey to be considered complete and count toward the 25 surveys per provider minimum requirement.

Best Practice Note:
Conducting Patient Experience of Care Surveys

Patient surveys, when done correctly, are an excellent way to gather feedback from your patients and identify areas for improvement. Clinics that wish to conduct a patient survey and implement best practices approaches should follow these additional specifications:

- Use mail, telephone, or email to administer the survey.
- Consider administering both adult and child-specific questionnaires depending on your patient populations.
- Ensure sample size is large enough to yield at least 45 completed surveys per provider FTE or 300 completed surveys per medical group. (Responses must be included from the patient panel of every provider at the clinic.)
- The recommended, or target, response rate is 40 percent.
- Include patients who have had at least one visit in the target time frame (the previous 12 or 6 months, depending on the survey version used).
- Include all patients who meet the sampling criteria even if they are no longer receiving care from the practice, site/clinic or provider.
- Ensure the sample selected for data collection is de-duplicated so that only one person per household receives a survey.
- Ensure that survey tools are linguistically and culturally appropriate, available in multiple languages and alternative formats, and take literacy into account based on your clinic's patient population
- Although not required to meet 1.A.1, the CAHPS Clinician and Group Survey with Patient Centered Medical Home items is recommended, which can be found at: http://cahps.ahrq.gov/clinician_group/.

To meet measures 1.A.2 and 1.A.3, clinics must meet all of the specifications for 1.A.1 and use the access to care questions (below) from one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools so that the data will be comparable to data from other clinics.

CAHPS survey tools are available to the public at no cost from the Agency for HealthCare Research and Quality (AHRQ) and can be accessed at the following web link: https://cahps.ahrq.gov/surveys-guidance/index.html

Several different CAHPS survey versions are available, as applicable to your clinic population. Any of the Clinician & Group Survey versions are recommended, and can be administered with additional questions, such as the Patient-Centered Medical Home Supplement, but this does not change the process for calculating your results. The Health Plans & Systems Survey is also acceptable to meet this measure, but is not the optimal tool to provide clinic-level data.

Best Practice Note:
CAHPS Surveys

While a variety of CAHPS survey tools are available, we recommend using the Clinician and Group Survey with Patient Centered Medical Home items, which can be found at: http://cahps.ahrq.gov/clinician_group/.

We also recommend using the AHRQ guidelines for survey administration available here: http://www.cahps.ahrq.gov/clinician_group/cgsurvey/fieldingcahps-cgsurveys.pdf

The following questions are included in the "Getting Timely Appointments, Care, and Information" domain for the Clinician & Group Survey:

> *"In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?"*
>
> *"In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?"*
>
> *"In the last 12 months, when you phoned this doctor's office during regular office hours, how often did you get an answer to your medical question that same day?"*

"In the last 12 months, when you phoned this doctor's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?"

"Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this doctor within 15 minutes of your appointment time?"

If you are using a different survey version, the questions may be slightly different, for example, the Child version of the survey includes all the same questions, but they are slightly reworded.

To meet measure 1.A.3, clinics must meet or exceed the benchmark for the "Getting Timely Appointments, Care, and Information" domain of the CAHPS survey that has at least 25 completed surveys per provider. If you use a vendor to administer the survey, you can use the overall domain score. Otherwise, the instructions to calculate your score are below. If the practice sees both children and adults, then they should report on both children and adults, and meet benchmarks for both age groups.

Please use the following instructions for calculating the top box score for the Getting Timely Appointments, Care, and Information domain from the CAHPS Clinician and Group Survey. Please visit the CAHPS website for more information about how to calculate your domain scores:
https://www.cahpsdatabase.ahrq.gov/files/CGGuidance/Preparing_Analyzing_Data_CG30_2035.pdf

For each question in the domain, calculate the proportions that choose the most positive response (i.e. always). For example, if 30 patients answered the first question, and 20 choose the most positive response (i.e. always) the proportion for that question is 67%. If 25 patients responded to the second question and 15 of them choose the most positive response (i.e. always), the proportion for the second question is 60%. Follow the same method to calculate the proportion for the remaining questions.

Then, to calculate the domain score, take the average proportion of all of the questions in that domain. In this example, calculate (67 + 60 + y + y + y) ÷ 5 = XX%. The top box score would therefore be XX% for the Getting timely appointments, care, and information domain.

CAHPS Access to Care Benchmarks[1]

CAHPS Survey Tool	Survey Version	Domain	Benchmark (%)
Clinician & Group	Adult	Getting Timely Appointments, Care, and Information	70%
Clinician & Group	Child	Getting Timely Appointments, Care, and Information	76%
Health Plans & Systems	Adult	Getting Needed Care	54%
Health Plans & Systems	Adult	Getting Care Quickly	59%
Health Plans & Systems	Child	Getting Needed Care	59%
Health Plans & Systems	Child	Getting Care Quickly	75%

[1] Benchmarks are the top box scores at the 75th percentile for the 2014 12/6-month 2.0 survey comparison scores published by the Agency for Healthcare Research & Quality (AHRQ). https://www.cahpsdatabase.ahrq.gov/CAHPSIDB/Public/CG/CG_About.aspx

Core Attribute 1: ACCESS TO CARE
Standard 1.B – After Hours Access

Measure:

1.B.1 - PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours. (5 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Many patients, caregivers, and families are unable to easily access appointments during traditional business hours. The intent of this standard is to ensure that patients, caregivers, and families who work during traditional business hours can still access care from their primary care home for both routine and urgent care.

Documentation Required – At a verification site visit, clinics should be able to produce documentation clearly showing weekly scheduling of after-hours routine and urgent appointments.

Specifications -
Definition of business hours - For the purposes of measure 1.B.1, "traditional business hours" are defined as 8:00am to 5:00pm, Monday – Friday, approximately 40 hours a week.

The after-hours solution must include access to urgent and routine preventive care, and be co-located[1]. However, for rural clinics with critical access shortages there may be creative solutions that meet the intent of this standard. Please contact the PCPCH program to discuss potential options.

Examples:
Practice strategies meeting the intent of this standard:

- Practice offers scheduled or walk-in in-person appointments at the same location as the PCPCH for a total of 4 hours weekly any time outside of traditional business hours.

[1] Co-located services share the same physical location and have instant access to the medical record.

Practice strategies not meeting the intent of this standard:

- Practice refers patients to an urgent care practice or the emergency department for all care outside of traditional business hours.
- After hours visits are for urgent issues only, and do not include comprehensive care delivery, such as acute care and routine care for chronic medical issues and preventive exam/service needs.

Core Attribute 1: ACCESS TO CARE
Standard 1.C – Telephone & Electronic Access

Measure:

1.C.0 - PCPCH provides continuous access to clinical advice by telephone. (Must-Pass)

This is a must-pass standard. Clinics must, at a minimum, meet measure 1.C.0 to qualify for PCPCH recognition at any level.

Intent – Access to clinical advice outside of in-person office visits is an important primary care home function associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that PCPCH patients, caregivers, and families can obtain clinical advice via telephone from a live person at all times.

Documentation Required – At a verification site visit, clinics should be able to produce documented examples of advice calls during both normal business hours and after-hours.

Specifications -

To meet 1.C.0, the clinic must have 24 hour a day, 7 days a week access to a live person via telephone for clinical advice for all patients of the clinic. Additionally, the clinic must have documented policy and procedures, including provider expectations for workflow and EHR access (if applicable), to ensure all after hours telephone encounters are documented in the EHR or paper chart within 24 hours of the call. It is not required that the person receiving the call, or giving clinical advice, has real-time access to the patient's medical record, although this would be ideal.

Examples:

Practice strategies meeting the intent of this standard:

- Business and after-hours phone calls answered by a live person and referred to a nurse or clinician[1] for clinical advice, as appropriate.
- Business and after hours phone calls answered by an on-call provider or nurse.
- Business and after hours phone calls answered by a live answering service with triage of appropriate calls to an on-call clinician or nurse (e.g. nurse advice line).

[1] A clinician is a licensed physician, resident physician, physician assistant (PA) or nurse practitioner (NP).

- Information about calls to the nurse advice line are faxed to the clinic each day and input into patients' medical records.

Practice strategies not meeting the intent of 1.C.0:

- Routine use of an answering machine to answer phone calls during or after business hours, with no option for patients to access clinical advice from a live person.
- Use of an automated message referring patients to the emergency room or an urgent care practice during or after business hours.
- Use of non-clinical staff (e.g. receptionist) to answer phone calls if staff do not have real time access to a clinician as dictated by appropriate protocols.

Best Practice Note:
Accessing Clinical Advice by Telephone

A small rural clinic has developed an innovative way to address the 24/7 access to clinical advice. They developed an on-call pool of providers from other clinics in the county and they all share call rotation. They don't have a common EHR, rather they resort to a paper process to document the after-hours calls. Each provider receives documentation templates and referral numbers for clinic providers in an on-call briefcase.
Providers are tasked with faxing or scanning and emailing to individual practices after-hours notes within 24 hours of the call.

Core Attribute 1: ACCESS TO CARE
Standard 1.D - Same Day Access

Measure:

1.D.1 - PCPCH provides same day appointments. (5 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Not all patient needs can be scheduled in advance. To provide the best care for patients and prevent excess utilization of emergency services, patients should have access to their primary care home for urgent needs that can be addressed in an ambulatory setting. Same day access is important for achieving the following outcomes: decreased wait times, decreased visit backlogs, decreased no-show rates, and increased patient satisfaction.

Documentation Required – At a verification site visit, clinics should be able to produce scheduling templates and of examples of completed same day appointments.

Specifications -
To meet the intent of this standard, clinics would reserve some appointments for patients that call that day with urgent needs or allow for specific times of the day when walk-in appointments are available. The same day appointments must be co-located at the clinic.[1]

Examples -
Practice strategies meeting the intent of 1.D.1:

- 10% of the average number of daily appointments are unfilled at the start of the business day based on an audit[2] of a representative sample.
- A written policy that includes directions for phone staff to ask patients if they need a same-day appointment, and a process to schedule these appointments as requested.

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[1] Co-located services share the same physical location and have instant access to the medical record.
[2] An internal records audit can be a useful way for a clinic to assess their own performance and standards exist to ensure the process is an accurate assessment of usual activities. For assistance setting up audits in your clinic, please see *Eight Steps to a Chart Audit for Quality* http://www.aafp.org/fpm/2008/0700/pa3.html

Practice strategies not meeting the intent of 1.D.1:

- The first appointment of the day is always overbooked.
- Patients calling with urgent needs are not scheduled, but a message is delivered to their PCP for consideration of an overbook.

Core Attribute 1: ACCESS TO CARE
Standard 1.E – Electronic Access

Measure:

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. (5 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent - When surveyed, patients indicate that electronic access to their health information and electronic communication is highly desirable[1]. A primary care home striving to provide access in the form patients prefer should facilitate access to their health information electronically.

Documentation Required – At a verification site visit, clinics should be able to produce documentation that meets the intent of one of the Meaningful Use measures listed in the specifications section below. Seventy-five percent or more of all providers (MD, DO, PA, NP, and ND) in the clinic must meet the Meaningful Use metrics for this measure, including providers who are ineligible for the EHR Meaningful Use Incentive Program.

Specifications –
Clinics must meet the specifications established by Centers for Medicare and Medicaid Services (CMS) for the EHR Meaningful Use Incentive Program. A clinic that meets the following Meaningful Use measure will qualify for PCPCH Measure 1.E.1:

- Stage 1 Meaningful Use core measure #12
  - More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.
- Stage 1 Meaningful Use menu measure #5
  - At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the

[1] Hassol, A. (2004). Patient experiences and attitudes about access to a patient electronic health care record and linked web messaging. *Journal of the American Medical Informatics Association*, *11*(6), 505-513. doi: 10.1197/jamia.M1593

certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.

- Stage 2 meaningful Use Objective 8: Patient Electronic Access.
    - Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

The specifications for these measures can be found by clicking the hyperlinks above or by visiting
http://www.cms.gov/Regulations-and Guidance/Legislation/EHRIncentivePrograms/index.html

Clinic providers that are ineligible for the EHR Meaningful Use Incentive Program can still meet the intent of this measure by following the same specifications.

Examples -
Practice strategies meeting the intent of 1.E.1:

- An electronic portal where patients, caregivers, and families can view records and lab results, ask questions, and request appointments or refills.

Practice strategies not meeting the intent of 1.E.1:

- Electronic newsletters with clinic information.
- A website without secure access to protected patient information.
- Electronic reminders about patient appointments.
- Electronic billing systems.

Core Attribute 1: ACCESS TO CARE
Standard 1.F - Prescription Refills

Measure:

1.F.2 - PCPCH tracks the time to completion for prescription refills. (10 points)

1.F.3 - PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent - The focus of this standard is on timely refills for important patient medications to avoid barriers or gaps in appropriate treatment. Timely prescription refills have been identified as crucial to control of chronic conditions [1]. Since this is a complex problem, measuring timely refills will help quantify current practices and establish a standard of care.

Documentation Required – At a verification site visit, clinics should be able to produce a log for tracking time to refill completion, the results of a chart review, or an electronic medical record report that includes tracking time to refill completion.

Specifications -
The easiest method of calculation for this measure would be to utilize an EHR system to calculate the time between the initial request from the patient/pharmacy to the clinic for a medication refill, and the completion of that request from the clinic to send the authorized refill back to the pharmacy or printing the prescription for the patient. If an EHR report is not available, clinics can conduct a chart audit of at least 30 patient records to determine refill completion times.

A refill is considered complete when it has been signed and becomes available for the patient to fill, either because a paper script is complete, or it has been ordered electronically. If the

[1] Odegard, P. S., & Gray, S. L. (2008). Barriers to medication adherence in poorly controlled diabetes mellitus. *The Diabetes Educator*, *34*(4), 692-697. doi: 10.1177/0145721708320558. In this study 21% of the patients indicated that their inability to obtain prescription refills was the cause of their non-adherence to prescribed medical regimens.

refill request is not approved, but canceled or denied, it would be counted as complete.

In order to **meet 1.F.3,** clinics must either meet a benchmark for prescription refill turnaround time or demonstrate improvement in prescription refill turnaround time.

To meet the benchmark, clinics must complete 90% of prescription refills within 48 hours over 12 months.

To meet **1.F.3** by improving prescription refill turnaround time, clinics must demonstrate ≥ 10 percentage point improvement over 12 months in the number of prescriptions refilled within 48 hours; or, ≥ 5 percentage point improvement over 6 months in the number of prescriptions refilled within 48 hours. The 48-hour timeframe includes business days only. If a refill request is received by the care team on a Friday, then Saturday and Sunday are not included in the 48-hour count unless the clinic operates with full staff on weekends.

For example, if a clinic previously demonstrated that 60% of prescription refills were completed within 48 hours, then a 10 percentage point increase would be demonstrated by achieving 70% of prescription refills being completed within 48 hours.

CORE ATTRIBUTE 2: ACCOUNTABILITY
Standard 2.A – Performance & Clinical Quality

Measures:

2.A.0 - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures. (Must-Pass)

2.A.1 - PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures. (5 points)

2.A.2 PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (10 points)

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. (15 points)

This is a must-pass standard. Clinics must, at a minimum, meet measure 2.A.0 to qualify for PCPCH recognition at any level. Clinics can also receive points for completing a more advanced measure, but this is not required for recognition.

Intent – Measuring and improving on clinical quality is a foundational element of primary care homes. The intent of these measures is to demonstrate that primary care homes have the capacity to monitor clinical quality data and improve their performance where appropriate. It is important for clinics to monitor clinical quality measures that reflect their patient population. For example, Family Practice clinics should be monitoring both adult and pediatric quality measures.

Documentation Required - Data submission required with application for 2.A.1, 2.A.2 and 2.A.3. At a verification site visit, clinics must be able to produce documentation of the raw data used to calculate the selected quality measures.

Specifications –
To meet this standard, clinics must collect data using the following procedures:

Eligible Quality Measures – Adult and Pediatric core set and menu set quality measures are found in the PCPCH Quality Measures: Technical Specifications section beginning on page 106. Any additional adult or pediatric core measure that a practice tracks can be used as a menu set measure.

Best Practice Note:
Selecting Quality Measures

It is considered best practice to report on measures that reflect the population the PCPCH serves. For example, clinics that care for both children and adults would ideally report on quality measures representative of both groups.

Data Collection –

- Clinics may collect quality data either by querying an electronic medical record system or by manual audit of an electronic or paper chart (a chart review).
- Clinics may also use quality measures produced from claims data by a 3rd party (e.g. an IPA, health plan, or the Oregon Health Care Quality Corporation) to meet these measures.[1] Clinics can submit their meaningful use measure results or those submitted for PQRS or similar pay-for-performance initiatives if the measures overlap with those in PCPCH.
- Clinics must aggregate the data across all providers and patients in the practice.
- Clinics must use quality measures that reflect their patient population.

Best Practice Note:
Conducting a Chart Review

For more information about setting up an internal audit for practice improvement, self-assessment or submitting data for your PCPCH quality measures, please see *Eight Steps to a Chart Audit for Quality* at http://www.aafp.org/fpm/2008/0700/pa3.html

Sampling – When auditing charts manually or by query of an electronic medical record, clinics must include in the sample all eligible patients during the sample period. For example, if a practice is tracking the frequency of hemoglobin A1C measurement in diabetic patients, it would review the chart of every patient with a diagnosis of diabetes who was seen during a period of time (e.g. first week of the month) sufficient to reach a sample size of at least 30

[1] Clinics submitting quality measures generated by a 3rd party from claims data must review this data prior to PCPCH application submission.

patients. The length of the sample period will vary based on how commonly a condition is seen in the practice, but should be within the 12 month period prior to application submission.

Calculation/Reporting of Results –

- Clinics must submit a numerator and denominator for each selected quality measure as part of the PCPCH application submission for 2.A.1, 2.A.2 and 2.A.3.
- For 2.A.0, data submission is not required at the time of application, but clinics must retain documentation of the data collected for the selected quality measure.
- Clinics must use the exact specifications for calculating and reporting their data. For technical details regarding the specific quality measures and instructions on how to calculate the numerator and denominator for each measure, please see the PCPCH Quality Measures: Technical Specifications section beginning on page 106.

Demonstrating improvement for 2.A.2 – In order to meet 2.A.2**,** clinics must demonstrate ≥ 10 percentage point improvement reported for all three quality measures over a period of 12 months, or ≥ 5 percentage point improvement for all three quality measures over 6 months.

Benchmarks for 2.A.3 - In order to meet 2.A.3, a clinic must meet the benchmark percentages ((numerator ÷ denominator) x 100) for all three reported quality measures, and must not report on a measure that does not have an established benchmark. Benchmarks are located in the Technical Specifications document beginning on page 111.

CORE ATTRIBUTE 2: ACCOUNTABILITY
Standard 2.B – Public Reporting

Measures:

2.B.1 - PCPCH participates in a public reporting program for performance indicators. (5 points)

2.B.2 - Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes. (10 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – As a means for increasing transparency and public awareness, opportunities for providers and clinics to make health care quality and outcomes data publicly available are on the rise. Compliance with this standard requires the clinic to leverage these opportunities by making data publicly available and refrain from "opting out" of these initiatives.

Documentation Required - At a verification site visit, clinics should be able to produce documentation as follows:
2.B.1 – A report or dashboard that is made available to the public through posting in a public area or website, distribution, or publication. The clinic must provide a copy of the report along with a description of how the information is made publicly available.
2.B.2 – A report or dashboard that is made available to the public through posting in a public area or website, distribution, or publication along with an example communication, poster, meeting minutes, etc. that demonstrates how this data is shared with all clinicians and staff in a clinic.

Examples -
Practice strategies meeting the intent of this standard:

- Participating in the Oregon Health Care Quality Corporation data collection program "Partner for Quality Care[1]" (2.B.1) and regularly sharing the reported data with providers and staff at the practice (2.B.2)

[1] http://www.q-corp.org/compare-your-care

- Reporting clinic-level performance data to a federal or state agency or initiative such as Centers for Medicare and Medicaid Services (CMS) and/or the National Healthcare Safety Network (2.B.1) which is then made publicly available. The data must be accessible by the public to meet the intent of this measure.

Practice strategies not meeting the intent of this standard:

- Sharing data outside of the practice without also sharing with clinic staff and clinicians (2.B.2).
- Sharing health plan or system-wide data without identifying clinic-level performance.
- Sharing clinic-level data that is not made publicly available.
- Participation in mandated reporting programs only, such as infectious disease reporting, etc.

CORE ATTRIBUTE 2: ACCOUNTABILITY
Standard 2.C – Patient and Family Involvement in Quality Improvement

Measures:

2.C.1- PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year. (5 points)

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. (10 points)

2.C.3 - Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – While all clinics aspire to be responsive to the needs of patients, caregivers, and families, formalizing their involvement in quality improvement to directly help increase the clinic's ability to be responsive to their needs has concrete advantages. While quality improvement (QI) is implicit to several other standards, these measures provide a roadmap for clinics to transform in their efforts to engage patients, caregivers, and families in quality improvement at the clinic.

Documentation Required - At a verification site visit, clinics should be able to provide documentation as follows:
2.C.1 – Transcripts from at least one patient focus group, minutes from a meeting, or communications between identified advisory group participants.
2.C.2 – Transcripts from multiple patient focus groups, meeting minutes, or communications between identified advisory group participants from an established, on-going advisory group. This cannot be limited to a one-time gathering of feedback, but clinics must demonstrate a defined, on-going effort.
2.C.3 – Job description, log of participation, training examples, and description of the program as whole.

Specifications –
"Per Year" is defined as the 12 months prior to PCPCH attestation (12 months prior to the day the PCPCH application is submitted).

Examples -
Practice strategies meeting the intent of measure **2.C.1:**

- PCPCH convenes a group of patients to provide feedback and guidance on how the practice can improve on specific areas of focus, for example:
    - Review and provide feedback on Patient-Centered Primary Care Home materials (i.e. brochures) before distribution
    - Review and provide feedback on patient shared care plan structure
    - Assess waiting room and office processes

Practice strategies meeting the intent of measure **2.C.2:**

- A patient, caregiver, and family advisory council maintained and routinely involved in data review and clinic strategy planning to improve and maintain patient experience.
- Patient, family, caregiver, or patient-defined family advisors are members on the clinic governing board or participating as a member of an on-going quality improvement team/committee.

Practice strategies meeting the intent of measure **2.C.3:**

- PCPCH has an established process for application, interview, orientation and training of patient advisors. Training should include topics such as HIPAA & signing of a confidentiality statement, safety, infection control, etc.
- Patient advisors used in administrative and/or patient care roles:
    - Regular patient, family, caregiver, or patient-defined family advisors participation in training activities for providers and staff.
    - Regular patient, family, caregiver, or patient-defined family advisors participation in interviewing potential new employees.
    - Patient, family, caregiver, or patient-defined family advisors participation in peer counseling or education/support groups organized by the practice.
    - Tracking information on patient advisory positions (e.g. identified positions, services provided, hours worked and performance evaluation).

A "peer" is any person supporting an individual, or a family member of an individual, who has similar life experience as the patients, caregivers, and families being served.

Best Practice Note:
Involving Patients in Quality Improvement

In addition to the strategies mentioned above, clinics implementing best practice approaches would include the following elements:

- Defined roles and responsibilities of a clinic liaison and advisors
- Defined opportunities for involving patient and family advisors (e.g., short-term projects, advisory councils, and advisors as members of quality/safety committee)
- Leadership, clinicians and staff are trained to work with advisors
- Patient and family advisors are recruited and trained appropriately (including the application, interview, orientation, & feedback process)
- Defined processes for implementing, coordinating and evaluating patient advisor activities

For more information on involving patients in quality improvement at your clinic, please see the following resources:

- Patient-Centered Primary Care Institute webinar *Preparing for Collaborative Work with Patient and Family Advisors:* http://www.pcpci.org/resources/webinars/preparing-collaborative-work-patient-and-family-advisors
- *Partnering with Patients and Families to Enhance Safety and Quality – A Mini Toolkit:* http://www.ipfcc.org/tools/Patient-Safety-Toolkit-04.pdf

CORE ATTRIBUTE 2: ACCOUNTABILITY
Standard 2.D – Quality Improvement

Measures:

2.D.1 - PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience. (5 points)

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. (10 points)

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. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Having a formal quality improvement (QI) program is an essential component of Patient-Centered Primary Care Homes[1]. While QI is implicit to several other standards, these measures outline the pathway that leads to strategic, integrated clinic-wide improvement. An explicit, comprehensive QI strategy is critical to efficiently collect, analyze, and act on data to improve care.

Documentation Required - At a verification site visit, clinics should be able to provide documentation as follows:
2.D.1 – Documents providing evidence of implementation of a quality improvement project, for example, implementation of a plan-do-study-act (PDSA) cycle.

[1] Medicare Payment Advisory Commission (MEdpAC) (2008) Report to Congress: Reforming the Delivery System, June, 2008. http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=11845

2.D.2 – Documents providing evidence of implementation of a quality improvement project, for example, implementation of a plan-do-study-act (PDSA) cycle, along with meeting minutes or other evidence of multi-disciplinary improvement team meetings and documentation of progress.
2.D.3 – An annual performance improvement plan/report that includes 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 plan/report includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.

Specifications -
"Regularly" is defined as 8-12 times per year.
"Per Year" is defined as the 12 months prior to PCPCH attestation (12 months prior to the day the PCPCH application is submitted).
"Multi-disciplinary" is defined as staff from multiple roles at the clinic – providers, support staff, management, and front desk/clerical staff.

Examples -
Practice strategies meeting the intent of measure **2.D.1**:

- The clinic implements quality improvement projects utilizing an improvement methodology (e.g. PDSA cycle) and performance data to direct and guide these projects.

Practice strategies not meeting the intent of 2.D.1:

- The clinic implements an improvement project, but cannot produce examples of data used and actions taken to improve on a clinical process.

Practice Strategies meeting the intent of **2.D.2**

- QI committee (or QI teams) meet regularly, and are multidisciplinary, or interprofessional, in their composition. In a very small clinic, the team might constitute the whole clinic, but there should be a defined process for transparent decision making.

Best Practice Note:
Using Data to Drive Quality Improvement

How will your clinic know if what you are doing is an improvement? Using high quality data that is collected using standardized, accepted approaches is critical for quality improvement. Please see information on accepted approaches available from the Institute for Healthcare Improvement at http://www.ihi.org/knowledge/Pages/default.aspx

- The progress of each improvement project is well documented and results are presented clinic-wide, and ideally, outside of the clinic.
- Solo practitioners can meet the intent by participating in an ongoing collaborative that covers the topic area of quality improvement.

Practice Strategies not meeting the intent of **2.D.2**

- Clinic staff participation on a QI team at an organization or health system level without clinic-level quality improvement implementation.

Practice strategies meeting the intent of **2.D.3.**

- In addition to the structure and processes in 2.D.2, a strategic plan for improvement has been developed, implemented, and it considers timing and integration of multiple improvement strategies.
- Best practices for improvement science have been implemented clinic-wide and can be documented.
- Improvement strategies should be based on multiple measurement inputs or data sources and include consideration of sustainability and a plan for spread of improvements.

CORE ATTRIBUTE 2: ACCOUNTABILITY
Standard 2.E - Ambulatory Sensitive Utilization

Measures:

2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population. (5 points)

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. (10 points)

2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent - Patient-Centered Primary Care Homes play a critical role in "bending the cost curve" by ensuring that ambulatory conditions are treated well, to the patients' satisfaction, and in the most cost-effective setting. High-quality, actionable data is needed in order to target areas for improvement.

Documentation Required – At a verification site visit, clinics must be able to produce raw data summaries and information used to collect and calculate any data, as well as improvement plans (for 2.E.2).

Specifications -
To meet any of the measures for Standard 2.E, data must be collected for at least one of the four measures below. The data must be calculated according to the specifications, must be specific to the clinic site that is applying for recognition, and must include the clinic's entire population of patients.

To meet 2.E.2, an improvement plan must address the data collected for 2.E.1.

1. **Measure Title: Ambulatory Care Sensitive Conditions**

Measure Description: This measure is used to assess the age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.

Measure Source/Author/Owner: Canadian Institute for Health Information (CIHI).

To access the specifications for this measure:

1) Visit the Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse website.
   Go to https://www.qualitymeasures.ahrq.gov/summaries/summary/48964
2) Print out the specifications for the measure you are planning to report on.
3) Calculate your clinic's data (numerator and denominator) according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

2. Measure Title: Care Transition – Transition Record Transmitted to Health Care Professional

Measure Description: Percentage of discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for which a transition record was transmitted to the facility or primary physician or health care professional designated for follow-up care within 24 hours of discharge, among Medicaid enrollees age 18 and older.

Measure Source/Author/Owner: American Medical Association-Physician Consortium for Performance Improvement.

To access the specifications for this measure:

1) Visit the Centers for Medicare and Medicaid Services (CMS) website and open the document *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2016*
   Go to: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

2) Go to page 41 and print out the specifications for the measure you are planning to

report on.

3) Calculate your clinic's data (numerator and denominator) according to the specifications found in the document except that clinics must calculate and report data patients. Clinics are not required to report on this measure for two age groups.

4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.
Definition of Active Patients – All patients with at least one office visit with any clinician or team member at the practice during the past 12 months. "Active patients" are a subset of the total number of patients that receive care at the clinic.

Numerator: Discharges for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Medical record review is required to collect the numerator data elements. (Note: If a given element does not apply to the enrollee, the transition record should include documentation stating the element is not applicable, e.g., no pending studies at discharge.)

The transition record must include the data elements specified in the Retrospective Data Collection Flowsheet (Figure CTR-A).

Denominator: All discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care, among enrollees age 18 and older as of December 31st of the measurement year.

Identify discharges from an inpatient facility using one of the following options:

- A code to Identify an Inpatient Facility (Table CTR-A) accompanied by a code to Identify Discharge Status (Table CTR-B), OR
- A code to Identify Outpatient Facilities (Table CTR-C) accompanied by a code to Identify Locations (Table CTR-D) AND a code to Identify Discharge Status (Table CTR-B)

3. Measure Title: Follow-Up After Hospitalization for Mental Illness

Measure Description: This measure is used to assess the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

Measure Source/Author/Owner: National Committee for Quality Assurance
Note: This is also an OHA state performance measure

To access the specifications for this measure:

1) Visit the Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse website.
   Go to*:* http://www.qualitymeasures.ahrq.gov/content.aspx?id=38895&search=0576
2) Print out the specifications for the measure you are planning to report on.
3) Calculate your clinic's data (numerator and denominator) according to the specifications found in the document except that clinics must calculate and report data on their entire population of active patients age 6 and older, not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

For clarification on "selected mental health disorders" use the specifications for Measure 13 in the Centers for Medicare and Medicaid Services (CMS) *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2013* found on page 50 at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

4. Measure Title: All Cause Readmission Rate

Measure Description: For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.

Measure Source/Author/Owner: National Committee for Quality Assurance
Note: This is also an OHA state performance measure

To access the specifications for this measure:

1) Visit the CMS website and open the document *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2013.*
   Go to: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf
2) Go to page 29 and print out the specifications for the measure you are planning to report on.
3) Calculate your clinic's data (numerators and denominators) according to the specifications found in the document except that clinics must calculate and report data on their entire population of patients age 18 and older, not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Note: Clinics that report on this measure are not required to submit their data (numerators and denominators) with their PCPCH application, however, at a verification site visit clinics must provide their data in the same table format as shown on page 33, Table 7.3 in the *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2013* found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

Benchmarks -
To meet 2.E.3, clinics must meet the benchmarks found below or demonstrate ≥ 10% improvement in reported scores over a period of one year, or ≥ 5% improvement over 6 months.

Measure 3: Follow-Up After Hospitalization for Mental Illness = ≥ 68%
Measure 4: All-Cause Readmission ≤ 10.5% (a lower readmission rate is better)

Benchmarking data is not available as of yet for measures 1 and 2. It will be reported by the Centers for Medicare and Medicaid Services (CMS) when enough data has been collected for comparison. Please contact the PCPCH Program at PCPCH@state.or.us if you have questions.

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.A – Preventive Services

Measures:

3.A.1 - PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence. (5 points)

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. (10 points)

3.A.3 - PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Preventive care is a core component of primary health care. The intent of this standard is to ensure that primary care homes are routinely providing access to age and gender-appropriate preventive care for the entire patient population served at the clinic. The scope of recommended preventive care is determined by best evidence. Each practice is not required to deliver all of the services themselves, but must have a process to ensure that all patients can access needed preventive services. The clinic should also have a process to coordinate the results of any screening tests.

Documentation Required – At a verification site visit, clinics should be able to provide multiple examples from medical records of age and gender appropriate preventive services and data report(s) of recommended screenings based on best-available evidence. For 3.A.2, clinics must also provide the improvement plan containing the required elements, and the data used as part of the improvement strategy. For 3.A.3, clinics should provide the raw data used to demonstrate meeting the 90% threshold and be able to describe their policy or workflow to ensure that patients are routinely provided recommended services.

Specifications -

Age and gender appropriate services based on best evidence that meet the intent of this standard are as follows:

- USPSTF Grade A and B recommendations[1]
- *Bright Futures* Recommendations for Pediatric Preventive Health Care[2]
- ACIP recommended vaccinations[3]
- HRSA-recommended preventive services for women[4]
- Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children[5]
- Standards of Care for CYSHCN Pediatric & Primary Care [6]

Best Practice Note: Evidence-Based Preventive Care

If your clinic uses an EHR template or health maintenance module for preventive care, it is considered best practice to review them regularly to ensure the preventive services offered are aligned with the most current evidence-based recommendations.

Examples -

Clinics attesting to any of the measures in this standard should be able to demonstrate routine provision of preventive care by demonstrating documented examples of the following types of activities in patient records:

- Routine scheduling of adult or child wellness examinations
- Use of templates, standard forms or flowsheets to document common screening, preventive services, counseling or anticipatory guidance (e.g. well child examinations, pap smears, Medicare wellness examinations, etc.)
- Documentation of orders and results for common screening tests (e.g. mammograms, colonoscopy, cholesterol measurement)
- Documentation of routine preventive procedures (e.g. immunizations, blood pressure measurement)

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[1] http://www.uspreventiveservicestaskforce.org/tools.htm
[2] http://brightfutures.aap.org/clinical_practice.html
[3] http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html
[4] http://www.hrsa.gov/womensguidelines/
[5] http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/
[6] http://www.lpfch.org/sites/default/files/field/publications/developing_structure_and_process_standards_charts.pdf

- Standardized pre-visit planning processes that include "scrubbing the records" to proactively find preventive care needs and "huddling" to review expected patient-specific care needs
- A care coordinator role responsible for the provision and coordination of preventive services for the clinic's patient population

To meet 3.A.2, the clinic must also have a documented improvement plan and strategy to increase the number of recommended age and gender appropriate preventive services provided to their patient population. The plan must include tracking and analyzing data related to provision/coordination of preventive services, identification of gaps in care, strategy for improving gaps in care, and data evaluating the effectiveness of the improvement strategy.

To meet 3.A.3, the clinic must provide or coordinate 90% ((numerator ÷ denominator) x 100) of the services appropriate for their patient population. **The percent of recommended services must be calculated using the specifications and table below**.

> **Numerator:** Number of recommended services in table below that are directly coordinated or provided by the clinic.
> **Denominator:** Number of recommended services in table below that apply to clinic population.

For example, if the clinic only sees children, there are 22 services on the table that apply to the population. The denominator would be 22, and in order to meet 3.A.3, the clinic would need to ensure the provision of at least 20 of these services (20 ÷ 22 = 91%).

Recommended Service	Source	Sub-population	Applicable	Offered
AAA screening	USPSTF	Men Age 65-75 who have ever smoked		
Age appropriate anticipatory guidance	BF	Children		
Alcohol misuse screening and behavioral counseling	USPSTF, BF	Adolescents, Adults		
Anemia Screening	USPSTF	Pregnant Women		
Aspirin Prophy	USPSTF	Adults aged 50-59 years		
Autism Screening	BF	Children		
Bacteriuria Screening	USPSTF	Pregnant Women		
BP Screening	USPSTF	Adults		

BRCA Screening Counseling	USPSTF	Women with family history of these mutations		
Breast Cancer Chemoprevention	USPSTF	Women at high risk for Breast Cancer		
Breastfeeding Counseling and support	USPSTF, HRSA	Pregnant women, postpartum women		
Cervical Cancer Screening	USPSTF	Adult Women		
Chlamydial Infection Screening	USPSTF	Women		
Colorectal Cancer Screening	USPSTF	Adults age 50-75		
Comprehensive Newborn Screening	USPSTF, HRSA	Newborns		
Contraceptive methods and counseling	HRSA	Adult and Adolescent Women		
Depression Screening	USPSTF	Adolescents, Adults		
Developmental Screening	BF	Children		
Diabetes Screening	USPSTF	Adults with hypertension		
Dyslipidemia Screening	USPSTF	At-risk children, Men age 20-35 at increased risk of heart disease, women aged 20-45 at increased risk of heart disease		
Fluoride chemoprevention	USPSTF	Children		
Folic Acid Supplementation	USPSTF	Pregnant Women		
Gestational Diabetes Screening	HRSA	Pregnant Women		
Gonococcal Opthalmia Prophylaxis	USPSTF	Newborns		
Gonorrhea Screening	USPSTF	Women		
Healthy Diet counseling	USPSTF	Adults with cardiac risk factors		
Hearing Loss Screening	USPSTF, BF	Children		
Hepatitis B Screening	USPSTF	Pregnant Women		

HIV Screening	USPSTF, HRSA	Women, At-risk Adolescents and At-risk Adults		
HPV Testing	HRSA	Adult Women		
Iron Supplementation	USPSTF	At-risk Infants		
Lead Screening	BF	At-risk children		
Mammography	USPSTF	Women		
Obesity Screening and Counseling	USPSTF	Children, Adults		
Oral Health Risk Assessment	BF	Children		
Osteoporosis Screening	USPSTF	Women 65 or older, At-risk younger women		
Rh incompatibility Screening	USPSTF	Pregnant Women		
Routine Vaccination	ACIP	Children, Adults		
Screening and counseling for interpersonal and domestic violence	HRSA, USPSTF	Women		
STIs counseling	USPSTF, HRSA	Adolescents, Adults		
Syphilis Screening	USPSTF	At-risk Adolescents, At-risk Adults, Pregnant Women		
TB Screening	BF	At-risk children		
Tobacco Use Counseling	USPSTF	Adults, Pregnant women		
Vision Screening	USPSTF, BF	Children		
Well Woman Annual Visits	HRSA	Women		

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.B – Medical Services

Measure:

> **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. (Must-Pass)**

This is a must-pass standard. Clinics must meet this standard to qualify for PCPCH recognition at any level.

Intent – Acute and chronic medical care for common problems is a core component of primary health care. The intent of this standard is to ensure that primary care homes are routinely providing access to both acute and chronic medical care for all of their patients.

Documentation Required – At a verification site visit, clinics must be able to provide examples of each of the services listed above from the clinicians' schedules and/or patients' medical records.

Examples -
Clinics attesting to this standard should be able to demonstrate routine provision of acute and chronic medical care by showing documented examples from all of the above categories. The following types of activities documented in patient records or clinician schedules would satisfy this requirement:

- Acute care for minor illnesses and injuries (e.g. respiratory infection, musculoskeletal injuries, urinary tract infection)
- Ongoing management of chronic conditions commonly seen in the practice's population (e.g. diabetes, asthma, obesity, chronic pain, depression, ADHD, hypertension) with coordination of specialty referrals as needed
- Office-based procedures and diagnostic tests (e.g. suturing of minor lacerations, splinting and casting, injections, biopsies, point-of-care urinalysis, x-ray, spirometry, EKG)
- Age and gender appropriate preventive services are offered or coordinated through the clinic. See table on page 45 for more information.

- Patient education and self-management support (e.g. age-appropriate anticipatory guidance at well child checks for safety, sleep, exercise, nutrition, etc.; diet and exercise counseling & instruction on self-management and home monitoring of chronic diseases such as diabetes, hypertension). For information about evidence-based self-management, please visit www.healthoregon.org/takecontrol.

Clinics should be able to demonstrate multiple examples of each of the above types of activities. Attestation to this standard indicates that the PCPCH clinicians view acute and chronic medical care as a key responsibility of the primary care home.

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.C – Behavioral Health Services

Measures: (Check all that apply)

3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes (Must-Pass)

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 (10 Points)

3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers (15 Points)

This is a must-pass standard. Clinics must meet measure 3.C.0 at a minimum to qualify for PCPCH recognition at any level. Clinics can receive points simultaneously for meeting the measures within this standard, making a total of 25 points possible.

Intent – Assessment and appropriate intervention for mental health, substance use and developmental, behavioral or social delays is a core component of primary health care. The evidence is clear that coordination and integration of care for individuals with mental health, substance use, or developmental conditions is strongly associated with improved health outcomes in these populations. The intent of this standard is to ensure that primary care homes are routinely assessing their patients for these issues, and providing appropriate treatment, referral and care coordination for these conditions.

This standard is not intended to determine the proportion of patients who receive indicated screening or intervention for these conditions.

Documentation Required – At a verification site visit, clinics should be able to provide examples of the following screenings from patient medical records: mental health (e.g., depression), substance use, and developmental conditions. The clinic must also be able to provide an up-to-

date list of onsite/local referral resources for those patients with mental health, substance abuse, and developmental, behavioral or social delays.

3.C.0 Specifications -

To meet 3.C.0, the clinic must utilize and be able to describe their protocol or process to conduct universal screening at the clinic for at least one mental health and substance abuse condition, and for developmental conditions as appropriate for the clinic's patient population. The process to address patients with a positive screen should also be identified and documented. In addition, clinics must utilize and be able to produce an up-to-date list of referral and community-based resources for commonly diagnosed mental, substance abuse and developmental, behavioral or social delays for patients requiring specialty care that meets the needs of their patient population.

Examples

Clinics meeting the intent of measure **3.C.0** would include completed examples of the following types of documentation in patient records:

- Age-specific developmental screening tools given at Bright Futures recommended periodicities for common developmental, behavioral or social delays (e.g. the Ages and Stages Questionnaire given to all children at the 9 month, 18 month and 30 month well-child visits and the M-CHAT-R autism screening tool given at 18 and 24 months). The clinic also must use an up-to-date list of referral resources for parents of children that have positive screens.
- Brief screening tools used routinely to assess for depression or another mental health conditions commonly seen in the practice's patient population. These screening tools should be universal (i.e. every patient is screened with some defined frequency, regardless of symptoms). Many clinics screen for depression using the Patient Health Questionnaire[1] (PHQ) screening tools for assessing depression. Screening for anxiety using tools such as the Generalized Anxiety Disorder (GAD) is another common example of mental health screening tool that clinics use. As with all screening protocols, clinic must have a defined strategy of action when screenings are positive.
- Additional standardized evidence-based screening tools administered routinely to evaluate for substance use and other health risk behaviors - examples include the SBIRT[2], CAGE, AUDIT, DAST, and CRAFFT (for adolescents).

[1] http://www.phqscreeners.com/

[2] http://www.samhsa.gov/prevention/SBIRT/index.aspx. Also see http://www.sbirtoregon.org/

- Patient intake, history, or screening forms, given to every patient on at least an annual basis, that document assessment of alcohol or substance use, mental health screening questions, and examples of management or referral for patients with positive screens.

Practice strategies not meeting the intent of **3.C.0**

- New patient intake forms with questions about mental health and substance abuse, but there is no other defined, routine screening strategy for these issues beyond the new patient appointment.
- Screening only at provider discretion or based upon diagnosis.

Best Practice Note:
Universal Screening in the Primary Care Home

It is considered best practice to implement screening strategies aimed at your clinic's entire patient population using evidence-based, verified screening tools administered at recommended periodicities. For example, if your clinic cares for both adults and children, you would implement screening protocols for both populations, which may require different screening tools. For example, a clinic that cares for both adults and children could implement the following screening protocols:

- For young children - Ages and Stages Questionnaire (ASQ) given to all children at the 9 month, 18 month and 30 month well-child visits (or 24 month if 30 is not offered) along with an M-CHAT-R screening tool at 18 and 24 months for autism.
- For adolescent patients - standardized screening tools for mental health (e.g. PHQ 2/9) and substance abuse (e.g. SBIRT, CRAFFT) at all adolescent well-child checks.
- For adults – a Patient Health Questionnaire (PHQ 2/9) and SBIRT screening tools given to all patients annually.

Ideally, your clinic's screening strategy should consider family and family environment, primary, secondary, and tertiary prevention.

Clinics that do not see children wouldn't necessarily screen for developmental conditions, but should strive to be responsive to the needs of disabled persons and recognize that many childhood developmental conditions persist in adulthood.

3.C.2 Specifications

Clinics meeting measure **3.C.2** must demonstrate evidence of a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed. The cooperative referral process may include the following elements:

- Providing reason for referral and relevant clinical information.
- Tracking referral status.
- Following up to obtain specialist's report.
- Documenting agreements with specialists for co-management.
- Providing systematic 2 way communication and exchange of patient information.

Clinics with co-located specialty mental health, substance abuse, and developmental providers must also have a cooperative referral process for external behavioral health providers to meet measure 3.C.2.

Collaboration, co-location and co-management require documentation of a systematic 2-way communication method or shared medical records. Shared medical records do not require that the clinics use the same electronic health record, but chart notes should be available to all treating providers at the time of each visit.

Examples

Clinics meeting the intent of measure **3.C.2** could provide examples of the following:

- Names of specialty providers for mental health, substance use and developmental issues commonly used by the PCPCH and documentation in the medical record detailing collaboration with these providers such as telephone encounters discussing particular patients, shared protocols for medication management, or regular meeting times.
- Regular two-way communication with specialty providers demonstrating active coordination of patient care, for example around assessment and diagnosis, treatment plan including medication management and laboratory monitoring, hospitalization, and/or community resource engagement.

3.C.3 Specifications

Clinics meeting 3.C.3 must have an on-site licensed behavioral health provider (MD, PhD, PsyD, PMHNP, LCSW, LPC, LMFT,) trained to work in a primary care setting delivering a broad array of comprehensive evidence-based behavioral health services for mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises,

developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization.

On-site behavioral health services should be available for enough hours each week to adequately address the needs of the clinic's patient population and meet the specifications for 3.C.3 described below.

Note: *Practices located in behavioral health provider shortage areas, such as rural communities, may provide behavioral health services virtually. Please email PCPCH@state.or.us for additional information.*

In clinics meeting 3.C.3 a behavioral health provider is available for same-day open access services include warm hand-offs, brief assessments and interventions for patient and families, consultations to primary care clinicians and other care team members, and participation in pre-visit planning and daily huddles.

At clinics meeting 3.C.3 physical and behavioral health providers use the same medical record system and participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles.

PCPCH utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of the PCPCH patient population. PCPCH utilizes written protocols for referrals to appropriate specialist(s) and hospitalization if clinically indicated.

Best Practice Note:
Behavioral Health Provider Staffing

Research on behavioral health provider staffing ratios in primary care practices is still emerging as more clinics move toward integrated care. The following resources can help inform your clinic's staffing:

Integrated Behavioral Health Alliance of Oregon, Recommended Minimum Standards for PCPCHs Providing Integrated Health Care
http://www.ccooregon.org/media/uploads/PCPCHibhaofinalwatermark2.pdf

Advancing Integrated Mental Health Solutions (AIMS Center), Guidelines for Care Manager [behavioral health provider] Caseload Size
https://aims.uw.edu/sites/default/files/CareManager_CaseloadSize_Guidelines_0.pdf

PCPCH identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model that includes these services.

Examples

Clinics meeting the intent of measure **3.C.3** could provide examples of the following types of activities:

- An on-site behavioral health provider who participates in team meetings, daily-huddles, pre-visit planning and quality improvement projects.
- A behavioral health provider who educates and trains all clinic staff on how to improve behavioral health services.
- Use of a shared electronic medical record by an on-site behavioral health provider to facilitate coordination and integration of patient care.
- A significant portion of the behavioral health provider's schedule is open for same-day consultations.

Practice strategies not meeting the intent of 3.C.2 or 3.C.3:

- Faxing chart notes between clinic and external behavioral health providers, without evidence in the medical record of two way communication between clinicians and specialty providers regarding co-management of patients' plan of care.
- Behavioral and physical health providers practicing in the same location, but no meaningful communication or coordination of patient care.

From the Field: Meeting the Intent of all Measures in Standard 3.C.

A Pediatric clinic in Woodburn has a robust screening process in place for assessing their patients for mental health and developmental conditions using the CRAFFT, ASQ and M-CHAT-R for their age appropriate patients. The clinic also administers the Edinburgh Postnatal Depression Screener to perinatal mothers. **These activities meet the intent of 3.C.0.**

The clinic has a co-located, bi-lingual behavioral health provider who is an employee of the public mental health program from the county health department. He is available for brief interventions and consultations and has documented, two-way communication and exchange of treatment plans with referring providers in the clinic. This co-located provider is a critical link between the clinic care teams and additional external mental and behavioral health providers. **These activities meet the intent of 3.C.2.**

The clinic also has a mental health nurse practitioner and a pediatrician who is an expert in ADHD who are employees of the clinic. They are both available for warm hand-offs, assessments, curbside consultations and also see their own patients. They use the same EMR and huddle with clinical teams daily. **These activities meet the intent of 3.C.3**

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.D – Comprehensive Health Assessment & Intervention

Measure:

> **3.D.1 - PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors. (5 points)**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Health risk behaviors and developmental, behavioral or social delays account for a large proportion of chronic medical conditions in both adults and children. The intent of this standard is to ensure that primary care homes assess and intervene in these risk factors as part of routine wellness care. This standard is not intended to assess the percentage of a PCPCH's patient population with certain risk factors or the percentage who received an intervention.

Documentation Required – At a verification site visit, clinics must be able to produce examples from the medical record of at least three health risk and (for the pediatric population) developmental promotion behaviors (e.g., alcohol/tobacco use, exercise/diet, sexual risk factors, injury prevention, developmental delay) and associated interventions (e.g. counseling, education and referrals).

Specifications -
To meet 3.D.1, a clinic must be able to list and demonstrate three risks or behaviors for which they provide assessment and intervention. The population assessed should be specific and identifiable. The process to intervene with patients with positive risk factors should also be explicit, and follow-up should be documented.

Common health risk behaviors include: tobacco use, alcohol or substance use, injury prevention,

Best Practice Note:
Assessing Health Risks

It is considered a best practice for primary care homes to address issues that are relevant to their entire patient population. For example, if a clinic sees children or adolescents, at least one of the assessments and interventions should be targeted at that population and should not solely be focused on adults.

diet, physical activity, interpersonal violence, adverse childhood events, and sexual health.

Intervention could include counseling and anticipatory guidance, provision of written educational material, referral to appropriate resources, prescription medication, referral to specialists, or scheduling follow-up appointments to monitor the health risk.

Examples -

Practice strategies meeting the intent of **3.D.1:**

- Use of patient intake forms, checklists or other charting tools that assess health risk behaviors common in the PCPCH's patient population, and documentation of appropriate intervention when a health risk is identified.
- For pediatric populations, standardized well-child check forms/templates that include age-appropriate assessments of risk such as safety, physical activity, diet/nutrition, etc. with anticipatory guidance.
- For senior populations, standardized Medicare wellness visit forms that include assessments for diet, tobacco, alcohol and substance use, physical activity, hearing, falls, and home safety. When risks are identified, clinic documents appropriate interventions such as referrals, education, counseling and continued follow-up with health care team members as needed. For information on how to incorporate evidence-based fall risk assessments and interventions at your clinic please visit: https://public.health.oregon.gov/PreventionWellness/SafeLiving/FallPrevention/Pages/STEADIToolkit.aspx
- For adult populations, patients complete an annual health history form that includes questions on tobacco, alcohol, and drug use, sexual activity, diet and exercise, etc., as well as provides interventions when risks are identified. For tobacco cessation resources for health care providers, please visit: http://www.smokefreeoregon.com/quit/quit-resources
- Alcohol (SBIRT[1]) screening and documentation of referral and follow up as needed. Validated, free screening tools are available from the referenced website for SAMHSA (Substance Abuse and Mental Health Services Administration), a federal Health and Human Services (HHS) agency.

[1] http://www.samhsa.gov/sbirt. Also see www.sbirtoregon.org

CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.E - Preventive Service Reminders

Measures:

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. (5 points)

3.E.2 - PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders. (10 points)

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. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent - In addition to providing comprehensive preventive services to patients, proactive outreach to patients, caregivers, and families regarding these services helps facilitate timely completion of needed screening and intervention.

Documentation Required – At a verification site visit, a clinic should be able to produce a Meaningful Use report, log, database, or other file of patients who need reminders and examples of actual correspondence with patients to remind of needed services.

About Meaningful Use: For eligible providers there is a difference between the Medicare EHR Incentive and the Medicaid EHR Incentive programs. The Medicare EHR Incentive Program, administered by CMS will provide incentive payments to eligible professionals, eligible hospitals and Critical Access Hospitals (CAHs) that demonstrate meaningful use of certified EHR technology.
The Medicaid EHR Incentive Program, administered at the state level, will provide incentive payments to eligible professionals, eligible hospitals, and CAHs as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of

participation and demonstrate meaningful use for up to five remaining participation years. Please see the Medicaid Electronic Health Records Incentive Program for more information.

Meaningful Use 2016 Program Requirements: In October 2015, CMS released a final rule that specifies criteria that EPs, eligible hospitals, and CAHs must meet in order to participate in the Medicare and Medicaid EHR Incentive Programs. The final rule's provisions encompass 2015 through 2017 (Modified Stage 2) as well as Stage 3 in 2018 and beyond.

Specifications -
To meet 3.E.1 clinics must demonstrate that the PCPCH sends reminders to patients for preventive/follow up care using a method that satisfies either Stage 1 or Stage 2 Meaningful Use Measures:

Meaningful Use Stage 1 Menu Set Measure 4

- More than 20 percent of all patients 65 years or older or 5 years or younger were sent an appropriate reminder during the EHR reporting period.

Meaningful Use Stage 2 Core Measure 12

- More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

The specifications for these measures can be found by clicking the hyperlinks above or by visiting http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Seventy-five percent or more of all providers (MD, DO, PA, NP, and ND) in the clinic must meet the Meaningful Use metrics for this measure, including providers who are not eligible for the EHR Meaningful Use Incentive Program.

To meet 3.E.2, the clinic must have a log, database, or other file that shows unique patients in need of preventive services and documentation that reminders are sent. The log must include patient names, outstanding recommended services with due date, dates of communication (letter, email, phone call) to the patient.

Unique Patient - If a patient is seen more than once during the last 12 months, then that patient should only be counted once.

To meet 3.E.3, the clinic must have a log, database, or other file that shows unique patients in need of preventive services, documentation that reminders are sent, and if the preventive

service was completed. The log must include patient names, outstanding recommended services with due date, dates of communication (letter, email, phone call) to patient, and dates of completed service.

Examples –

Practice strategies meeting the intent of this standard:

- Using a log, file or recall list that includes unique patient names, outstanding recommended services with due date, dates of communication (letter, email, phone call) to patient, and dates of completed service to proactively outreach to patients reminding them of needed preventive services.
- Postcard reminders or mailings to female patients age 24-65 that have not had a pap smear in 3 years asking them to schedule an appointment for a well woman exam.
- Calling every patient with diabetes with no recorded HbA1c in the last 6 months to ask them to come in for a lab draw, and documenting that those calls were made.
- Sending reminders for women who are due for mammography.

Practice strategies not meeting the intent of this standard:

- Posting signs in the clinic, or materials on the website, about recommended preventive services.
- Sending out a clinic “newsletter” with a non-personalized list of ages and recommended preventive services.

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.A – Personal Clinician Assigned

Measures:

4.A.0 - PCPCH reports the percentage of active patients assigned to a personal clinician or team. (Must-pass)

4.A.3 - PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (15 points)

This is a must-pass standard. Clinics must, at a minimum, meet measure 4.A.0 to qualify for PCPCH recognition at any level. Clinics can also earn 15 points if they meet the continuity benchmarks for 4.A.3.

Intent – Interpersonal continuity of care is a core component of primary care, and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that primary care homes are able to monitor and measure whether patients are assigned to a personal clinician or health care team. Primary care homes should seek to promote patients' relationships with their personal clinician and health care team. Not all clinics have implemented a team-based care model, and among those that have, the team composition may look different from clinic to clinic. For those operating in a team-based care model, the focus should be on how the teams function to provide continuity of care for their patients including shared communication and responsibility for a defined set of the clinic's population. Also, patients should know which team they belong to, and understand that they are known by other members of their health care team.

Documentation Required – Data submission required with application[1]. At a verification site visit, clinics must be able to provide documentation of their patient assignment process and policies, and provide summaries of the raw data used to calculate the data.

[1] Clinics with a single clinician (solo practices) still need to submit data for this measure; however, single clinician PCPCHs are assumed to have 100% assignment with a personal clinician.

Specifications -
To meet this standard, clinics must collect and submit data using the following procedures:

> **Numerator:** Number of active patients who are currently assigned to a personal clinician or team.
> **Denominator:** All patients meeting the definition of "active patient."

Definition of Active Patients – All patients with at least one office visit with any clinician or team member at the practice during the past 12 months prior to PCPCH application submission. "Active patients" are a subset of the total number of patients that receive primary care at the clinic.

Sample Size – Clinics have one of two options for compiling data:

1) Generate a report from an electronic system demonstrating the percentage of all active patients at the clinic with an assigned personal clinician.
2) If the clinic does not have an electronic system for compiling the data, the clinic can conduct a random chart audit of at least 30 active patient records to determine if a primary clinician or team is assigned.

Note: the same data collection method for 4.A should be used for 4.B.

Benchmark – To meet 4.A.3, 90% or more ((numerator ÷ denominator) x 100) of a practice's active patients must be currently assigned to a personal clinician or team.

Sampling Frequency – Practices are expected to assess the percentage of patients with an assigned personal clinician at least annually.

Personal Clinician or Team Assignment – Clinics that have implemented the team-based model of care can report continuity data based on patient visits with their health care team. All other clinics must report continuity data based on individual clinician assignment. Clinics must demonstrate a standard method of documenting all patients' assignment to a personal clinician or team. Examples of strategies to document assignment of a personal clinician include use of a standard field in an electronic medical record or practice management software, or clear identification of the personal clinician or team on a patient's paper chart. Whenever possible, patients' assignment to a personal clinician or team should be based on patient choice.

Definition of Team – The definition of "team" may vary from practice to practice but should ideally be no larger than up to six members[1] (e.g. clinician, nurse care manager, medical assistant, front desk staff, behavioral health provider, community health worker) and contain up to two full time (MD/DO + NP/PA) clinicians. Alternatively, a "teamlet" model[2] may be used. **Ideally, the entire clinic should not be designated as a team for any clinic with more than 2 providers.** If team and not individual clinician is used for continuity calculations, then patients must be routinely notified/informed of which team they belong.

Sample calculation for 4.A:

In the last 12 months a clinic has 3,428 patients that have had at least one office visit at the clinic. Out of these 3,428 patients, 2,987 patients are assigned to a personal clinician or team.

4.A. Numerator = 2,987
4.A. Denominator = 3,428
% for 4.A. = 87.14%
In this example, the clinic did not meet the 90% benchmark for 4.A.3

[1] The VA Pact Model (http://www.va.gov/primarycare/pact/) provides a successful outline for a team model that includes the patient, a provider, an RN care manager, a medical assistant, and an administrative staff member.
[2] A teamlet consists of a provider and a medical assistant, CNA, or LPN that regularly work together as a subunit of the larger team. They should be attached to an expanded support team (administrative staff, care manager, etc).
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.B – Personal Clinician Continuity

Measures:

4.B.0 - PCPCH reports the percent of patient visits with assigned clinician or team. (Must-pass)

4.B.2 - PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (10 points)

4.B.3 - PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (15 points)

This is a must-pass standard. Clinics must, at a minimum, meet measure 4.B.0 to qualify for PCPCH recognition at any level. Clinics who meet either measure 4.B.2 or 4.B.3 also meet this and will receive points for achieving the more advanced measure.

Intent – Continuity of care is a core component of primary care, and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that primary care homes can measure and improve patients' continuity with an assigned personal clinician or health care team over time. Primary care homes should seek to promote patients' relationships with their personal clinician and/or health care team. Not all clinics have implemented a team-based care model, and among those that have, the team composition may look different from clinic to clinic. For those operating in a team-based care model, the focus should be on how the teams function to provide continuity of care for their patients including shared communication and responsibility for a defined set of the clinic's population. Also, patients should know which team they belong to, and understand that they are known by other members of their health care team.

Documentation Required – Data submission required with application[1]. At a verification site visit, clinics should be able to provide summaries of the raw data used to calculate the continuity data.

[1] Clinics with a single clinician (solo practices) still need to submit data for this measure; however, single clinician PCPCHs are assumed to have 100% continuity with a personal clinician.

Specifications –

To meet this standard, clinics must collect and submit data using the following procedures: Practices are required to report a numerator and denominator at the time of application submission for this standard.

> **Numerator:** Number of patient visits during the last 12 months when patients saw their assigned clinician or team.
>
> **Denominator:** Total number of patient visits during the last 12 months for patients meeting the definition of "active patient." *Note: If the practice does not include RN or other care team member visits in the numerator (e.g. behavioral health), exclude these visits from the denominator.*

Definition of Active Patients – All patients with at least one office visit with any clinician or team member at the practice during the past 12 months prior to PCPCH application submission. "Active patients" are a subset of the total number of patients that receive primary care at the practice.

Sample Size – Clinics have one of two options for compiling data:

1) Generate a report from an electronic system demonstrating the total numbers of patient visits at the clinic with an assigned personal clinician or team during the 12 months prior to PCPCH application submission.
2) If a clinic does not have an electronic system for compiling the data, they can conduct a random chart audit of at least 30 active patient records to determine the number of patient visits with assigned clinician or team.

Note: the same data collection method for 4.B should be used for 4.A.

Sampling Frequency – Clinics are expected to assess continuity of visits with the patients' clinician/health care team at least annually.

Definition of Team – Clinics that have implemented the team-based model of care can report continuity data based on patient visits with their assigned health care team. All other clinics must report continuity data based on individual clinician assignment. The definition of "team" may vary but should ideally be no larger than up to six members[1] (e.g. clinician, nurse care manager, medical assistant, front desk staff, behavioral health provider, community health

[1] The VA Pact Model (http://www.va.gov/primarycare/pact/) provides a successful outline for a team model that includes the patient, a provider, an RN care manager, a medical assistant, and an administrative staff member.

worker) and contain up to two full time (MD/DO + NP/PA) clinicians. Alternatively, a "teamlet" model[1] may be used. Ideally, the entire clinic should not be designated as a team for any clinic with more than 2 providers. If team and not individual clinician is used for calculations, then patients must be routinely notified/informed of which team they belong.

There are some circumstances that may warrant calculating continuity numbers differently, such as the use of locums or clinicians on maternity/paternity leave. If you have questions about how to calculate your clinic's continuity data, please contact the program office at PCPCH@state.or.us.

To meet measure 4.B.2, clinics must demonstrate ≥ 10 percentage point improvement in reported scores over a period of one year, or ≥ 5 percentage point improvement over 6 months.

Benchmark – To meet 4.B.3, 80% or more ((numerator ÷ denominator) x 100) of patient visits during the last 12 months for those patients who are assigned a personal clinician or team are with the patient's assigned personal clinician or team.

Sample calculations for 4.B:

4.B.3 In the last 12 months, 3,428 unique patients had a total of 9,323 visits at a clinic. Out of these 9,323 visits, 7,010 visits were with the patients' assigned personal clinician or team.

> **4.B. Numerator** = 7,010
> **4.B. Denominator** = 9,323
> **% for 4.B.** = 75.19%
> In this example, the clinic did not meet the 80% benchmark for 4.B.3

4.B.2 In the last 12 months, another clinic showed a 10% increase from the previous year in the number of visits with the assigned personal clinician or team.
2015 = 7,543 visits with the assigned clinician out of 11,423 **7543/11432** = 66%
2016 = 8944 visits with the assigned clinician out of 11,665 **8944/11665** = 76%
In this example, the clinic did meet demonstrate ≥ 10% point improvement in reported scores over a period of one year and receives 10 points for 4.B.2.

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[1] A teamlet consists of a clinician and a medical assistant, CNA, or LPN that regularly work together as a subunit of the larger team. They should be attached to an expanded support team (administrative staff, care manager, etc).
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.C – Organization of Clinical Information

Measure:

> **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. (Must Pass)**

This is a must-pass standard. Clinics must meet this standard to qualify for PCPCH recognition at any level.

Intent – Primary care homes must maintain comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as patients move throughout the health care system. Maintaining a health record with up-to-date information is an essential pre-requisite to managing safe transitions of care between health care providers.

This measure does require standardized collection of the above elements, but is not intended to require an electronic health record.

Documentation Required –At a verification site visit, clinics that are using a "Meaningful Use" certified electronic health record (EHR) would not need to provide additional documentation, although the visit will include an assessment of how these elements are updated in the practice. If the clinic is not using a "Meaningful Use" certified EHR, they must be able to provide examples of each of the elements listed above AND a workflow process that demonstrates how these elements are regularly reviewed and updated.

Specifications - Clinics meeting the intent of 4.C.0 must be able to provide examples of all of the required elements and be able to demonstrate a process for how these elements are regularly assessed and updated by practice staff. Documentation of each element must be standardized across all patient records. Clinics are not expected to calculate the percentage of complete patient records or demonstrate that every element is complete in each patient record.

Examples -

Practice strategies meeting the intent of 4.C.0:

- Standardized problem lists, medication lists, allergy lists and immunization records located in a consistent place in paper charts or in discrete fields in an electronic medical record

- Standardized location for documenting preferred language in a paper or electronic record
- Use of paper growth charts located in a consistent place in the paper record or an electronic system that automatically generates growth charts or percentiles in pediatric patient charts
- Recording of basic demographic information (e.g. name, address, phone number, insurance information, other contact information) in a consistent location in a paper or electronic chart
- Practice has a clear process and demonstrates the above data elements are reviewed and updated regularly (e.g. nurse or medical assistant reviews medications at each visit, front desk staff verifies demographic and insurance information at check-in, growth chart updated at each well child visit, administered immunizations are documented on the immunization flow sheet, etc.)

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.D – Clinical Information Exchange

Measure:

> **4.D.3 - PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). (15 points)**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Continuity of health care information during care transitions is important for both patient safety and reducing unnecessary utilization of services. Advanced primary care homes should not only maintain a comprehensive health record for each patient, but be able to send and receive electronic records (including but not limited to problem lists, medication lists, allergies, laboratory and imaging results, e-prescriptions and refill orders and recent clinic notes) to other health care providers, labs and pharmacies in real time to facilitate safe and effective transitions of care. The ability to have health information where and when it is needed is at the heart of this standard.

Documentation Required –At a verification site visit, clinics must be able to provide the name(s) of the software/system used to share real-time patient information electronically with hospitals, ERs, and specialty providers (e.g. problem lists, labs, chart notes, medications, etc.). The clinic should also be able to demonstrate examples of exchanging data with other entities.

Specifications –
Clinics meeting the intent of 4.D.3 must demonstrate that key information from individual patient records (e.g. problem lists, medication lists, allergies, laboratory and imaging and other diagnostic test results and recent clinic notes) is available to other health care providers especially hospitals, emergency departments and frequently used specialists. Lab orders and receipt of results should be done electronically whenever possible and e-prescribing should be the primary way that prescriptions are ordered, both for original and refill requests.

Examples -

Practice strategies meeting the intent of 4.D.3:

- Arrangement with usual hospital, emergency and specialty care providers to have real-time electronic access to the clinic's electronic health records or use of a shared electronic health record
- Use of CareAccord[1] (Direct Secure Messaging) or other health information exchange (HIE) solutions to ensure providers in a PCPCH have at least one option for exchange with other unaffiliated providers, care coordinators, and patients, regardless of the type of electronic health record system in use
- Participation in an organized local or statewide health information exchange organization, through registration with a Direct Messaging Health Information Service Provider or through a local or statewide record locater service, once available.
- Meeting the specifications established by CMS for the EHR Meaningful Use Incentive Program for Stage 2 measure 15, "Summary of Care."
- Capacity to exchange information, even if the majority of partner organizations do not share this capacity. In this case, capacity is defined as immediate capability should a partner organization become able to receive and send information. This capacity can be tested and documented according to CMS meaningful use guidelines: http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/electronic-exchange-of-clinical-information.

Practice strategies not meeting the intent of 4.D.3:

- Having a one-directional portal to see lab or imaging results in the local hospital EHR
- Participation in immunization registry
- Electronic reporting of laboratory tests to public health department
- Secure Faxing or e-Faxing of patient records with other providers or care entities
- Referral tracking and management systems.

[1] https://www.careaccord.org/

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.E – Specialized Care Setting Transitions

Measure:

> **4.E.0 - PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (Must-pass)**

This is a must pass standard. Clinics must meet this standard to qualify for PCPCH recognition at any level.

Intent – Care coordination and communication during care transitions is an important aspect of patient safety, especially between inpatient and outpatient care settings. Primary care homes should take responsibility for facilitating appropriate transitions of care by developing working relationships with their usual providers of hospital care.

Documentation Required –At a verification site visit, clinics must be able to produce a copy of the written agreement, including evidence that the usual providers of hospital care agree to the principles, policies, and procedures in the agreement.

Specifications -
Definition of Usual Hospital Providers – The hospital(s) or hospitalist group(s) that most frequently care for the primary care home's patient population when admitted to a hospital or visiting the Emergency Room.

Clinics meeting the intent of 4.E.0 must be able to identify the usual providers of hospital care for their patients (e.g. a specific hospital(s) or hospitalist group(s)) and have a written agreement in place with the usual hospital providers so that the primary care home is notified when patients are admitted and discharged.[1] Written agreements with usual providers of hospital care should contain the following types of information:

- Process for requesting hospital admission

[1] PCPCHs that have clinicians providing their own hospital care routinely for clinic patients do not need to have a written agreement in place. However, if a clinic is part of a system that includes a hospital, the clinic must still have a written agreement unless clinicians at the PCPCH clinic provide hospital care routinely for their patient population.

- Process and performance expectations for communication at the time of hospital admission
- Process for sharing of patient medical records at the time of hospital admission
- Process and performance expectations for communication at the time of hospital discharge
- Process and performance expectations for scheduling after-hospital follow up appointments

Best Practice Note:
Care Setting Transitions

To ensure the best continuity of care between the primary care home and hospitals, it is considered best practice to have written agreements with all of the hospitals in the area that a clinic's patients may go to. It's also a good idea to have a provision in the agreement to ensure that exchange of information between hospitals and the primary care home is timely.
For resources on care setting transitions, including an example hospital agreement, please visit the Patient-Centered Primary Care Institute website at www.pcpci.org

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.F - Planning for Continuity

Measure:

> **4.F.1 - PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available (5 points).**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – This standard is a functional step inherent to completion of several others. In order to respond in a timely way to refill requests, clinical questions, and lab results, it's important to have a plan for those times when care team members are not available.

Documentation Required – At a verification site visit, clinics must be able to provide copies of the policy establishing the mechanism, as outlined below. If implemented properly, all staff should be to easily describe its use and details.

Specifications -
A mechanism is the standardized procedure a clinic uses to track provider availability and assign coverage for administrative requests, prescription refills, and clinical questions.
This must include:

- Procedure to notify covering providers and team members of absences
- Explicit requirement that staff arrange coverage for absences of specific duration
- Contact information and method for all staff
- Procedure to report unplanned absences
- Identification of responsible person for tracking provider availability
- Identification of responsible person for assigning coverage
- Explicit expectations for covering providers and other care team members

Examples -
Practice strategies meeting the intent of 4.F.1:

- Urgent patient requests are automatically routed to a covering provider when their team members are unavailable, and patients are notified if a non-urgent request won't be completed within a specified time frame.

- On-call providers are responsible for patient requests when team members are not available, and there is always an on-call provider designated.
- Specific care team members are responsible for in-basket coverage, and know who is responsible for monitoring in case of an absence.
- Locum providers are available when other providers are unavailable.

Practice strategies not meeting the intent of 4.F.1:

- Patient requests are routinely postponed until their provider is again available.
- Coverage is not designated to a particular person during times when team members are unavailable.

CORE ATTRIBUTE 4: CONTINUITY
Standard 4.G - Medication Reconciliation and Management

Measures:

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. (5 points)

4.G.2 - PCPCH develops a process, tracks and reports the percentage of patients whose medication regimen is reconciled at each relevant patient encounter. (10 points)

4.G.3 – PCPCH provides Comprehensive Medication Management for appropriate patients and families. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent - The inclusion of medication reconciliation and management is based on evidence that significant health problems are caused in part by medication errors. A comprehensive approach to providing effective primary care should address this issue by working to prevent medication errors. This is also a critical component to care transitions for complex patients and ongoing medication management for patients with complex or high-risk medication concerns.

Documentation Required – At a verification site visit, the clinic must be able to provide documentation as follows:

4.G.1 – Demonstrating the function and measurements outlined in the Specifications section below describing Meaningful Use measures can meet the intent of this PCPCH measure. Clinics participating in Medicare or Medicaid Meaningful Use must be able to provide documentation that meets Meaningful Use Stage 1 Menu Set Measure 7, or Stage 2 Core Measure 14.
4.G.2 – Clinic must provide documentation that demonstrates there is a process for, and tracking of, the percentage of patients with reconciled medication regimens.
4.G.3 – Clinic must provide a written clinical pharmacist job description, documented examples of comprehensive medication management plans that contain the required elements (see

below), and, if applicable, any collaborative practice agreements between the pharmacist(s) and other members of the care team.

Specifications -
Medication Reconciliation - The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. This also includes establishing care with a new primary care provider.

To meet 4.G.1, clinic providers that are ineligible for the CMS EHR Meaningful Use Incentive Program can still meet the intent of this measure by following the same specifications.

- Meaningful Use Stage 1 Menu Set Measure 7
- Meaningful Use Stage 2 Core Measure 14

The specifications for these measures can be found by clicking the hyperlinks above or by visiting

http://www.cms.gov/Regulations-and Guidance/Legislation/EHRIncentivePrograms/index.html

Clinic providers that are ineligible for the EHR Meaningful Use Incentive Program can still meet the intent of this measure by following the same specifications.

To meet 4.G.2, clinics are not required to submit data with their application, however clinics must calculate and document data according to the specifications below and must be able to demonstrate the raw data as well as resulting percentage ((numerator ÷ denominator) x 100) at a verification site visit:

> **Numerator:** Number of relevant patient encounters, as below, where medication reconciliation was performed.
> **Denominator:** Number of relevant patient encounters in one year in which the practice was the receiving party of the transition.

To meet 4.G.3, clinics must provide documentation at the time of the site visit demonstrating a comprehensive medication management plan is in place for patients with complex or high-risk

medication concerns. Examples of complex or high-risk concerns are: patients who are prescribed multiple medications; patients taking medications that have a narrow therapeutic index, such as, anticoagulants or psychiatric medications; transitions of care; or patients who are prescribed medications for chronic illnesses, such as, diabetes, chronic pain, Attention Deficit Hyperactivity Disorder or asthma. The comprehensive medication management plan must include the following and be developed in partnership with patients:

- medication reconciliation during office visits and transitions of care
- clear communication of desired clinical outcome(s) for each medication in use
- monitoring of progress toward desired clinical outcome(s)
- review and discussion of therapeutic goals with the patient and care team
- planned follow-up intervals with the patient

Examples –

Practice strategies meeting the intent of **4.G.3.**

- Integration of a clinical pharmacist into the care team who performs the following types of functions: meets with patients and caregivers to obtain and document a complete medication history; reviews medical records and assesses patients' clinical status to ensure medications are appropriate, effective and safe (e.g. evaluating blood pressure in patients on antihypertensive therapy); development and implementation of care plans in partnership with patients; and, planned follow-up evaluation and medication monitoring that includes assessment of patients' progress toward treatment goals.
- Clinic implements a written collaborative practice agreement[1] between clinical pharmacist(s) and other members of the care team.
- Clinic has a standardized process to identify their patients with complex or high-risk medication needs, and a process to work with the patients to create a medication management plan containing at least the elements above for those patients

Practice strategies not meeting the intent of **4.G.3**:

- Care team member(s) performing medication reconciliation at an office visit, with minimal to no documented proactive, coordinated, team-based medication management activities in place
- Utilizing a pharmacist who functions operationally in isolation from other members of the care team and lacks opportunity to collaborate in real time with the care team and patients

[1] https://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf

Best Practice Note:
Preventing Medication Errors

Comprehensive Medication Management is the provision of the following services utilizing the professional practice of pharmaceutical care by a licensed pharmacist or other health care professional:

(1) Assessment of the patient's health status including the personal medication experience and use patterns of all prescribed and OTC medications;
(2) Documentation of the patient's current clinical status and clinical goals of therapy;
(3) Assessment of each medication for appropriateness, effectiveness, safety and adherence focusing on achievement of desired clinical goals;
(4) Identification of all drug therapy problems including additions or deletions in medications or changes in dosage needed to meet desired clinical goals;
(5) Development of a comprehensive medication therapy plan for the patient in consultation with the prescribing practitioner that is aligned with recognized standards of practice;
(6) Documentation and follow up of the effects of recommended drug therapy changes on the patient's clinical status and savings in overall costs including ER visits and hospitalizations.

For more information, go to:
http://www.pcpcc.net/guide/patient-health-through-medication-management

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION
Standard 5.A – Population Data Management

Measures: (Check all that apply)

> **5.A.1 - PCPCH demonstrates the ability to identify, aggregate, display and utilize up-to-date data regarding its patient population, including the identification of sub-populations (5 points).**
>
> **5.A.2 - PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior (10 points).**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard. Clinics can receive points simultaneously for meeting the measures within this standard, making a total of 15 points possible.

Intent – In order to coordinate and manage care, a primary care home should be able to produce, track and proactively utilize basic information about its patient population. Clinics should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease or health care need.

Documentation Required – At a verification site visit, the clinic must be able to produce data reports for the clinic's patient population for 5.A.1 (e.g., age, gender, diagnosis code, medication, patient registry), and data reports of sub-populations (e.g., mammograms, well-child appointments, HbA1c, lists of patients being follow up after emergency room discharge). The clinic must also be able to produce examples of how the clinic uses the data reports to track and proactively manage patients with specific conditions or health care needs.
For 5.A.2 clinics must be able to demonstrate the risk stratification process utilized in the clinic, and produces lists of patients meeting criteria for increased risk.

Specifications –
Measure **5.A.1** requires a practice to demonstrate the use of population-based data generated for the purposes of patient management or tracking of a particular disease state or health care need. Management implies that a practice actively monitors the health care needs of a population of its patients and seeks to identify and correct "gaps" where indicated care has not been given.

Measure **5.A.2** requires a practice to demonstrate the implementation and use of an evidence-based risk stratification process to identify patients who are at the highest risk. It is critical that the risk stratification process involves all patients of all ages who receive primary care in the PCPCH.

Examples –

Practice strategies meeting the intent of **5.A.1:**

- PCPCH queries its practice management system or EHR to identify the practice's most commonly seen diagnoses or produce aggregated demographic information about its patient population (e.g. most common chronic conditions in the clinics population, percentage of patients in certain age groups or by gender, race, ethnicity, and preferred language).
- PCPCH maintains an active searchable registry of patients with a specific condition (e.g. diabetes or pregnancy). For more information on registries, please see the footnotes. Registries can sometimes be integrated in the EHR, but clinics can also use simple Excel tracking systems[1].
- PCPCH uses a list of patients to generate patient reminder outreach for indicated care (e.g. mammograms, well-child appointments, immunizations, etc.)
- PCPCH maintains a registry of patients with diabetes or asthma and tracks the percentage of patients up-to-date on indicated care and testing (e.g. hemoglobin A1c, on appropriate medications)
- PCPCH keeps a registry of pregnant women and follows up with women who miss appointments for prenatal care.
- PCPCH generates an inclusive list of patients in the practice who have a particular health behavior (like smoking, BMI, or abnormal screening tests) to target health promotion activities or needed follow up.

Practice strategies not meeting the intent of **5.A.1:**

- PCPCH has the capability to generate a list of patients in the practice who have a particular diagnosis (like diabetes, hypertension) or health behavior (like smoking, obese BMI, or abnormal screening tests), but the clinic does not regularly use this capability,

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[1] Oritz, D. (2006). Using a Simple Patient Registry to Improve Your Chronic Disease Care. Family Practice Management, 13(4), 47-52. http://www.aafp.org/fpm/2006/0400/p47.html
Also please see: Bagley, B., & Mitchell, J. (2011). Registries Made Simple. Family Practice Management, 18(3), 11-14. http://www.aafp.org/fpm/2011/0500/p11.html

and they do not routinely use such data for the purposes of patient management or tracking of the particular disease state or health care needs/interventions.

Examples -

Practice strategies meeting the intent of **5.A.2:**

- PCPCH implements a risk stratification strategy for their patient population based upon disease states, psychosocial risks, and/or cultural/linguistic-based risks to help most effectively target interventions, care coordination, and care planning resources.
- PCPCH utilizes an evidence-based tool or process to stratify their patient population based upon risk, and can provide lists of patients and their risk assignment.
- PCPCH collaborates with an IPA or other organization to assign risk stratification to their patient population, and can produce lists of patients and their risk assignment.
- PCPCH documents the process for regularly reviewing the risk stratification assignments for their population and adjusts scores accordingly.

Practice strategies not meeting the intent of **5.A.2**:

- PCPCH has performed a risk stratification process but only for a subset of their patient population.
- PCPCH has performed a risk stratification process but has not periodically reviewed and adjusted scores accordingly.

Best Practice Note:
Risk Stratification

Stratification is a statistical concept that implies that a practice can report on the proportion of patients with a specific problem. This data can then be used to target interventions. Risk stratification is not a static process, continual review is required to adjust risk scores according to changes in patient condition.

For more information, please visit

http://pcpci.org/sites/default/files/resources/Risk-Stratified%20Care%20Management%20and%20Coordination.pdf

http://www.aafp.org/news/practice-professional-issues/20141104riskstratify.html

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION
Standard 5.B – Electronic Health Record

Measure:

> **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. (15 points)**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Implementation and use of an electronic health record is an essential tool for achieving many advanced primary care home functions, such as improved population tracking, care coordination, improved communication and patient safety. The Centers for Medicare and Medicaid Services (CMS) have established rules and incentive programs for health care providers who demonstrate "Meaningful Use" of an electronic health record.[1] Information on how this program operates in Oregon can be found at: http://medicaidehrincentives.oregon.gov. Rather than develop independent criteria for electronic health records, the PCPCH program chose to use the CMS criteria.

Documentation Required – At a verification site visit, clinics must be able to produce copies of the "Medicare & Medicaid EHR Incentive Program Registration and Attestation System" form for each Meaningful Use provider at the clinic. If the clinic providers are ineligible for payment, clinics must produce documentation confirming the clinic is using certified EHR technology, their Meaningful Use worksheet produced from the EHR, and information about why the clinic/providers are ineligible.

Specifications -
A practice meeting the intent of 5.B.3 should be able to demonstrate the following:

- implementation of a Meaningful Use certified electronic health record
- use of the electronic health record in accordance with CMS Meaningful Use criteria
- receipt of EHR incentive payments through either the Medicaid or Medicare program

If the providers at the clinic are ineligible to receive the incentive payments, clinics can meet the intent of this measure by using a certified EHR system and producing a Meaningful Use scorecard.

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[1] www.cms.gov/EHRIncentivePrograms/

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION
Standard 5.C – Complex Care Coordination

Measures: (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. (5 points)

5.C.2 - PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (10 points)

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. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard. Clinics can receive points simultaneously for meeting the measures within this standard, making a total of 30 points possible.

Intent – Care coordination is an essential feature of a primary care home. The intent of this standard is to ensure that primary care homes deliberately consider care coordination functions, explicitly assign these functions to specific staff members, take extra steps to coordinate the care of patients with complex care needs, and communicate clearly to patients about who they can contact at the clinic to help coordinate their care. This standard also promotes the development of individualized care plans for patients with complex medical and social needs to help coordinate and integrate these patients' care. Identifying patients with higher health risks, implementing a strategy to help those most in need, and effectively coordinating and managing care for higher risk sub-populations can help avoid exacerbations of illness and other health complications.

Documentation Required – At a verification site visit, the clinic must be able to provide documentation as follows:

5.C.1 - clinic must be able to identify person(s) responsible for care coordination, provide a written description of their role/functions, and a method for notifying patients of who is responsible for coordinating their care.
5.C.2 - clinic must produce written criteria used to identify patients for care coordination (e.g., patients with chronic care needs, patients with multiple chronic diseases, etc.) and a description of activities performed by staff to assist with care coordination.
5.C.3 - clinic must provide examples of patient-centered care plans that contain the required elements (see below).

Specifications -
5.C.1 requires both clear assignment of care coordination responsibilities to practice staff and clear communication to patients about how to obtain these services. Care coordination functions within the practice do not need to be assigned to a single person. Some care coordination activities may be performed by clinical staff (e.g. motivational interviewing, support of behavior change, patient education) while others may be performed by non-clinical staff (follow up on referral and test results). However, patients should be informed whom to contact for specific needs related to care coordination, and the functions on the team pertaining to care coordination must be clearly defined in writing for each relevant team member.

5.C.2 requires that the clinic has a specific process and criteria for identifying patients who need extra help with care coordination due to complex health care needs. Examples of groups of patients with complex health care needs might include: children with special health care needs, adults or children with certain chronic diseases or multiple chronic disease, individuals taking multiple medications, individuals seeing several specialists, multiple recent hospitalizations, etc.

5.C.3 requires the clinic to develop and implement whole-person, individualized written care plans for the clinic's identified complex patients containing at least the following elements:

- patient-identified self-management goals
- goals of preventive and chronic illness care

Best Practice Note:
Care Coordination Training
When developing a care coordination program, clinic staff should be adequately trained for these new roles. Additional training is usually required because most health professional training programs have not traditionally provided adequate training in this area. Information on the chronic care model and specific care coordination functions will be essential.
Visit the Patient-Centered Primary Care Institute website where you can search for care coordination resources at www.pcpci.org

- action plans for exacerbations of chronic illness

Care plans should be developed collaboratively with each patient and be reviewed with each patient before finalizing, shared with patients' in their preferred language, documented in the medical record, and be updated regularly.

Examples -

Practice strategies meeting the intent of **5.C.1**:

- written job descriptions assigning certain care coordination functions to particular staff
- demonstration that certain staff members perform care coordination roles (e.g. staff member X maintains a log tracking test results)
- clear verbal or written instructions are provided to patients on who to contact to follow up or obtain needed services

Practice strategies meeting the intent of **5.C.2:**

- written criteria the practice uses to identify patients with "complex health care needs"
- list or roster of patients meeting the practice's internal criteria
- written description of activities and demonstration of the activities performed by clinic staff to assist with care coordination for individuals with complex health care needs
- demonstration that practice staff have received specific training, such as providing patient education or supporting behavior change, regarding the health care needs of patients meeting the practice's definition (e.g. diabetic education or training in preventing adverse events related to polypharmacy)

Practice strategies meeting the intent of **5.C.3**:

- In a pediatric setting, a clinic has a standardized process to identify their children with special health care needs (CSHCN) and a process to work with the families to create a shared care plan containing at least the elements above for those patients.

Practice strategies not meeting the intent of **5.C.3**:

- Clinician includes a medical "assessment and plan" portion in the visit note in the chart

Best Practice Note:

Care Coordination Functions

Below are examples of care coordination functions that should be considered when developing roles within the care team:

- Provision of separate visits and care coordination interactions
- Managing and tracking tests and referrals
- Coaching patients and families
- Facilitating transitions of care
- Use of health information technology
- Continuous management of communications internally and externally for the care team and patients
- Development of care plans in collaboration with patients and families
- Completion and analysis of patient assessments
- Integration of critical care information

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION
Standard 5.D – Test & Result Tracking

Measure:

> **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.** (**5 points)**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Test tracking is an important aspect of care coordination. This standard is intended to ensure that primary care homes actively track ordered tests and reliably assure that patients, caregivers, and families and clinicians are adequately informed of test results.

Documentation Required – At a verification site visit, a clinic must be able to produce a "snapshot" or other demonstration of their internal test tracking system and processes (e.g., labs, imaging), including whether results have been received and confirmation that results were communicated to the ordering clinician and to the patient.

Examples -

Practice strategies meeting the intent of **5.D.1:**

- Using a log or other system to track tests (laboratory tests, imaging, etc.) ordered in the clinic. The log or tracking system should clearly identify whether test results have been received and whether the patient and ordering clinician have been informed of test results.
- Interpretation of results is clear, documented, and has been provided to ordering clinicians and patients. This interpretation should include whether the test result is normal or abnormal for the patient and include information on follow up and/or next testing interval.

Practice strategies not meeting the intent of **5.D.1:**

- Clinic relies on external entities (lab or radiology department) to notify patients of test results and cannot determine using its own systems if patients have been notified.
- Clinic tracks only received test results, but cannot determine if a test has been ordered, but not performed.

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION
Standard 5.E – Referral & Specialty Care Coordination

Measures: (Check all that apply)

5.E.1 - PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. (5 points)

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). (10 points)

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. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard. A clinic can achieve points simultaneously for different measures, making a total of 30 points possible for this standard.

Intent – Primary care homes are a critical partner in the health care neighborhood. Understanding and coordinating patient care provided outside the primary care home is thus an important role. Additionally, primary care homes should strive to integrate care delivered in other care settings and also coordinate with community providers. This type of care coordination can help improve patient safety, reduce medication errors and improve patient empowerment, experience, and understanding of their health. These measures are intended to ensure that primary care homes take responsibility for coordinating care that occurs outside their walls.

Documentation Required – At a verification site visit, clinics must be able to documentation as follows:
5.E.1 - a referral log including status of referral, receipt of consultation report, and confirmation that results were communicated to patients.

5.E.2 - examples from the medical record of care coordination for patients in hospitals, skilled nursing or long term care facilities that demonstrate two-way communication between the PCPCH and clinicians coordinating care in these specialized care settings.
5.E.3 - a log for tracking referrals to community-based agencies (e.g., dental, social service, foster care, community health workers, etc.) with documented patient follow up and examples of two-way communication with community agencies that demonstrates care coordination.

Specifications –
Clinics meeting the intent of **measure 5.E.1** must be able to demonstrate a system for tracking specialty referrals. Tracking must include the status of the referral (e.g. appointment completion status, appointment date, urgency of the referral) as well as whether a consultation report has been received by the clinic and if results have been communicated to the patient. The clinic should also have a written policy in place for when and how to track specialty referrals. Examples of tracking systems could include:

- use of a paper log or tracking system which clearly identifies referral status (appointment made, completed or not, urgency) and identifies if consultation reports have been received and whether the patient and ordering clinician have been informed of test results.
- use of an electronic system within or independent of the practice's electronic health record which clearly identifies referral status (appointment made, completed or not, urgency) and identifies if consultation reports have been received and whether the patient and ordering clinician have been informed of test results.

Best Practice Note:
Tracking Referrals in the Health Care Neighborhood

Primary care homes should strive to coordinate and track all of the care their patients receive outside the primary care home. The "health care neighborhood" is not necessarily a geographic community, but a set of relationships revolving around patients, based on each individual's health care needs.
For example, clinics should strive to track referrals to specialty mental health and community-based resources such as housing and food assistance, using the same processes that the clinic would use to track any specialty medical referral.

Clinics meeting the intent of **measure 5.E.2** must be able to demonstrate active involvement in patient care when patients are either hospitalized or in skilled nursing or long-term care

facilities. Clinicians who directly manage this care in either setting are assumed to meet the measure. For patients not directly managed by PCPCH clinicians, the following kinds of activities would demonstrate active involvement:

- examples of regular two-way communication between the PCPCH and clinicians managing care in a facility
- tracking of patients admitted to facilities with active discharge planning and scheduling of follow-up appointments
- regular direct communication with patients receiving care in facilities to facilitate coordination and follow-up scheduling.
- A clinician at the PCPCH serves as medical director, or provides regular in-house visits, for a long term care facility where the majority of the patients in the practice receive care
- providing regular home-visits to patients who reside in long term care or group home settings

Clinics meeting the intent of **measure 5.E.3** must be able to demonstrate tracking of referrals and coordination of care provided by community entities related to the health of patients. Examples of community entities could include dental clinics, educational programs, social service agencies, foster care, public health agencies, school-based health care providers, community health workers, and pharmacy services. Activities that would meet the intent of this measure could include:

- maintaining a log of referrals to community entities and documenting completion of referrals and follow up as appropriate
- examples of collaborative management of patient health, documented in individual patient charts, including two-way communication with community organizations

For tobacco cessation resources for health care providers, please visit: https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/GetHelpQuitting/Pages/oregonquitline.aspx
For how to set up tobacco cessation referral systems using electronic health records, please visit: http://www.smokefreeoregon.com/quit/quit-resources
For information on community-based self-management programs, please visit: http://public.health.oregon.gov/PreventionWellness/SelfManagement/Pages/index.aspx

CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION
Standard 5.F – End of Life Planning

Measures:

> **5.F.0 - PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (Must-Pass)**
>
> **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). (5 points)**

This is a must-pass standard. Clinics must meet 5.F.0, at a minimum, to qualify for PCPCH recognition at any level. Clinics may receive additional points if they also attest to 5.F.1, but it is not required for recognition.

Intent – Arranging for culturally appropriate end-of-life and palliative care is an important aspect of care coordination for patients, caregivers, and families. This standard is intended to ensure that primary care homes engage their patients, caregivers, and families in end of life discussions, routinely assess patients' need and eligibility for hospice or palliative care when appropriate, and refer patients for these services or coordinate services within the clinic. It is also important for clinics to ensure patient wishes are documented in advance directive forms available in the patients medical record or through physician orders recorded in the medical record (i.e. POLST) which reflect the patients' wishes for their end-of-life care.

Documentation Required – At a verification site visit, clinics must be able to produce a list of hospice or palliative care providers that patients are referred to and examples from the medical record that end-of-life care planning was provided when appropriate (e.g., hospice care, advance directives and/or POLST). The clinic must also be able to provide documentation showing that appropriate forms are submitted to available registries regularly (5.F.1).

Specifications –
POLST – Physician Orders for Life-Sustaining Treatment

Primary care homes are not required to directly provide hospice or palliative care, but must have a process in place to refer and coordinate those services when patients and families need them.

Examples -

Practice strategies meeting the intent of **5.F.0**

- list of usual referral providers for hospice or palliative care (including admission criteria for these providers) and examples of patients referred to hospice or palliative care
- examples of encounters for counseling patients regarding hospice or palliative care referral
- examples of hospice or palliative care plans developed or approved by PCPCH clinicians

Practice strategies meeting the intent of **5.F.1**

- completed examples of end-of-life planning documents such as advanced directives, living wills, or POLST forms contained within patient records

Practice strategies not meeting the intent of **5.F.1**

- PCPCH can provide some copies of POLST forms in patient charts, which are not routinely filled out with the help of the PCPCH clinicians, and the clinic cannot provide any other example of advance directive counseling or help to complete advance directive documentation.

CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE
Standard 6.A – Language/Cultural Interpretation

Measures:

> **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. (Must-Pass)**
>
> **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. (5 points)**

This is a must-pass standard. Clinics must meet at least 6.A.0 to qualify for PCPCH recognition at any level. Clinics may receive additional points if they also attest to 6.A.1, but it is not required for recognition.

Intent – Cultural and linguistic proficiency is a core component of person and family-centered care. The intent of measure 6.A.0 is to ensure that primary care homes communicate with patients, caregivers, and families in their language of choice using trained medical interpreters. Further, there is a strong evidence base supporting the benefits of translating written materials (6.A.1)[1].

Documentation Required – At a verification site visit, clinics must be able to produce a list of interpreter services used at the clinic (e.g., face-to-face, telephonic, bi-lingual staff, sign language, TTY) and written guidelines for providing services to patients in the language of their choice. For 6.A.1, the clinic must be able to provide documentation and examples demonstrating that routinely used documents have been translated into all languages spoken by more than 30 households or 5% of the clinic's patient population, whichever one is less.

Specifications –
For 6.A.0, interpretation services should be offered either on-site or telephonically for all patients at the clinic that speak languages other than English and must be provided free of charge to patients. Interpretation services should be offered and available during the patients'

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[1]2012 PCPCH Standards Advisory Committee Report
http://www.oregon.gov/oha/OHPR/HEALTHREFORM/PCPCH/docs/PCPCH%20SAC%20Report%20FINAL%203_12_13.pdf

entire office visit and for telephone encounters. Patients may decline the use of interpreters, but should be informed that interpreters are available free of charge and have distinct advantages. Some clinics ask patients who refuse interpretation services to sign a waiver.

Examples -

Practice strategies meeting the intent of **6.A.0:**

- use of bilingual staff to communicate with patients or family members in their language(s) of choice throughout their entire office visit and during telephone encounters.
- use of a real-time telephonic interpreter (e.g., Passport to Languages[1], Pacific Interpreters[2], LanguageLine Solutions[3], etc.) to communicate with patients in their language of choice throughout their entire office visit and/or during telephone encounters.
- use of an in-person interpreter to communicate with patients in their language of choice throughout their entire office visit and/or during telephone encounters.

Practice strategies not meeting the intent of **6.A.0**:

- routine use of patient family members to act as interpreters for non-English speaking patients.
- interpreter services, providers, or other employees acting as translators, available at some times during clinic business hours, but not available at other times **and** the clinic does not have a strategy to provide alternative options for interpreter services the times when the employee(s) or services are unavailable and for patient languages for which the providers or employee(s) cannot offer proficient interpretation.

For 6.A.1, documents used routinely (e.g. privacy statements, consent forms, after-hours contact information, and self-management information provided regularly to patients and families such as well child anticipatory guidance information, and diabetes dietary/management information given regularly to patients with diabetes) must be translated into all languages spoken by more than 30 households or 5% of the clinic's patient population, whichever one is less.

[1] https://www.passporttolanguages.com/
[2] http://www.pacificinterpreters.com/
[3] http://www.languageline.com/solutions/industries/healthcare-interpretation/

Examples -

Practice strategies meeting the intent of **6.A.1:**

- patient education materials (printed, or electronic) that are readily available and provided to patients in their language of choice for all languages spoken by more than 30 households or 5% of the clinic's patient population.

Best Practice Note:
Communicating with Patients

To assess patients' language and communication needs, clinics should document their preferred language, including other communication needs (e.g. sign language, TTY, etc.), and whether or not interpretation services are needed. This will help identify which patients will benefit from these services, and allow you to assess the most commonly used languages by your patient population. Additionally, it is recommended that bilingual staff, interpreters and translators be certified through a regulatory agency such as the Oregon Healthcare Interpreters Certification Program or the National Board of Certification for Medical Interpreters (NBCMI).

Please visit: https://www.oregon.gov/oha/oei/Pages/hci-certification.aspx

For additional information on translating into plain language and effectively communicating with patients, please see *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care:* A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.
http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE
Standard 6.B - Education & Self-Management Support

Measures:

6.B.1 - PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate. (5 points)

6.B.2 - More than 10% of unique patients are provided patient-specific education resources. (10 points)

6.B.3 - More than 10% of unique patients are provided patient-specific education resources and self-management services. (15 points)

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – A critical component of person and family-centered care is empowering patients and their families to manage their own health and wellness through patient engagement and self-management support. The intent of this standard is to ensure that primary care homes give their patients the tools they need to engage in self-management.

Documentation Required – At a verification site visit, clinics must be able to produce a list of educational materials and community resources routinely provided to patients (e.g., brochures, handouts, classes, websites, etc.). Information could include diagnosis, prognosis and treatment of certain conditions; health promotion; managing conditions. For 6.B.2 and 6.B.3 the clinic must be able to provide examples of the patient education and self- management services provided at the clinic and raw data summaries.

Specifications -
Patient-Specific Education - the process by which health professionals and others impart information to patients and their caregivers that will alter their health behaviors or improve their health status.

To meet 6.B.1, a clinic must have a process and protocol in place to ensure that up-to-date patient-specific education resources are provided to patients on a variety of topics relevant to the clinic's patient population.

To meet 6.B.2, clinics must track and calculate data on how many patients receive patient-specific educational resources. The resulting percentage ((numerator ÷ denominator) x 100) must be more than 10% in order for the clinic to meet this measure.

> **Numerator:** Number of patients in the denominator who were provided patient-specific educational resources during the last 12 months.
> **Denominator:** Number of unique patients seen by the clinic during the last 12 months.

Unique Patient - If a patient is seen more than once during the last 12 months, then that patient should only be counted once in the denominator for the measure.

Clinics can also meet this measure if they meet any of the following Meaningful Use measures that align with PCPCH measure 6.B.2:

- Meaningful Use Stage 1 Menu Set Measure 6
- Meaningful Use Stage 2 Core Measure 13

To meet 6.B.3, clinics must track and calculate data on how many patients receive patient-specific educational resources AND self-management services. The resulting percentage ((numerator ÷ denominator) x 100) must be more than 10% in order for the clinic to meet this measure.

> **Numerator:** Number of patients in the denominator who were provided patient-specific educational resources AND self-management services during the last 12 months.
>
> **Denominator:** Number of unique patients seen by the clinic during the last 12 months.

Unique Patient - If a patient is seen more than once during the last 12 months, then that patient should only be counted once in the denominator for the measure.

Self-management services - the interventions, training, and skills by which patients, including those with a chronic condition, disability, or disease, can effectively take care of themselves and learn how to do so. To enable patients to engage in enhanced self-care, they can be supported in various ways and by different service providers.

Examples -

Practice strategies meeting the intent of 6.B:

- providing patients with educational information about basic diagnosis, prognosis, exacerbations and/or treatment of conditions (patient education)
- providing education to promote healthy behaviors and/or resources to support behavior change (patient education)
- educating families on normal childhood development and providing anticipatory guidance, education and support (patient education)
- referring patients to resources for further education and peer-learning (clinics should be able to demonstrate common referral sources) (patient education)
- assessing patient activation or readiness to engage in behavior change and self-management using validated assessment tools and strategies (self-management services).
- providing patients with tools to support self-management of chronic conditions (e.g. templates, action plans or home monitoring flowsheets) (self-management services)
- Self-management support groups provided at the clinic such as chronic pain or stress management, Living Well with Chronic Conditions[1] classes, diabetes walking groups, etc. (self-management services)

For more information on patient education and self-management resources, please visit: www.healthoregon.org/takecontrol and www.healthoregon.org/livingwell.

[1] For more information on Living Well with Chronic Conditions classes, please visit http://public.health.oregon.gov/diseasesconditions/chronicdisease/livingwell/Pages/Index.aspx

CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE
Standard 6.C – Experience of Care

Measures:

> **6.C.0 - PCPCH surveys a sample of its patients and families 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. (Must-Pass)**
>
> **6.C.2 - PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process. (10 points)**
>
> **6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process, and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness. (15 points)**

This is a must-pass standard. Clinics must meet at least 6.C.0 to qualify for PCPCH recognition at any level. Clinics can receive additional points if they also attest to 6.C.2 and/or 6.C.3., but it is not required for recognition.

Intent – To be truly person and family centered, a primary care home should understand the care experiences of its patients and their family members and seek to improve the care experience where appropriate. One of the CAHPS survey tools is recommended for measure 6.C.0 and required for measures 6.C.2 and 6.C.3.

Documentation Required –At a verification site visit, clinics must be able to produce the survey forms implemented, and all data from the last survey conducted (number of responses, dates conducted, and results).

Specifications –
To meet 6.C.0 clinics must collect data using the following procedures:

- Clinics must conduct a patient experience of care survey to collect feedback from patients, caregivers, and families.
- Patient experience survey questions must assess these areas: access to care, provider or

health team communication, coordination of care, and staff helpfulness. The CAHPS survey is recommended but not required.

- Clinics must obtain survey results for a minimum of 25 completed patient surveys per provider each time the survey is administered.
- Patients must be included from all providers who have an assigned patient panel at the clinic.
- Clinics must include all completed survey results in reported data.
- 50% or more of the survey questions must be answered for the survey to be considered complete and count toward the 25 surveys per provider minimum requirement.
- Clinics should survey patients in a way that is both random and anonymous. Examples of an appropriate survey methodology could include distributing a patient survey to every 5th patient or surveying all patients with appointments during a specific time period.
- Clinics may directly survey patients or conduct a patient survey through a 3rd party vendor (e.g. Press Ganey, National Research Corporation, etc.).
- Surveys may be collected on paper, via telephone or electronically.
- Although not required to meet 6.C.0, the CAHPS Clinician and Group Survey with Patient-Centered Medical Home items is recommended, which can be found at: http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/index.html

Best Practice Note:

Conducting Patient Experience of Care Surveys

Patient surveys, when done correctly, are an excellent way to gather feedback from your patients and identify areas for improvement. Clinics that wish to conduct a patient survey and implement best practices approaches should follow these additional specifications:

- Use mail, telephone, or email to administer the survey.
- Consider administering both adult and child-specific questionnaires depending on your patient populations.
- Ensure sample size is large enough to yield at least 45 completed surveys per provider FTE or 300 completed surveys per medical group. (Responses must be included from the patient panel of every provider at the clinic.)
- The recommended, or target, response rate is 40 percent.
- Include patients who have had at least one visit in the target time frame (the previous 12 or 6 months, depending on the survey version used).
- Include all patients who meet the sampling criteria even if they are no longer receiving care from the practice, site/clinic or provider.
- Work to ensure the sample selected for data collection is de-duplicated so that only one person per household receives a survey.
- Ensure that survey tools are linguistically and culturally appropriate, available in multiple languages and alternative formats, and take literacy into account based on your clinic's patient population.

To meet 6.C.2 or 6.C.3 clinics must collect data using the following procedures:

Clinics must meet all of the specifications for 6.C.0 and use one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools so that the data will be comparable to data from other clinics.

CAHPS Survey tools are available to the public at no cost from the Agency for HealthCare Research and Quality (AHRQ) and can be accessed at the following web link: https://cahps.ahrq.gov/surveys-guidance/index.html

Several different CAHPS survey versions are available, as applicable to your clinic population. Any of the Clinician & Group Survey versions are recommended, and can be administered with additional questions, such as the Patient-Centered Medical Home Supplement, but this does not change the process for calculating your results. The Health Plans & Systems Survey is also acceptable to meet this measure, but is not the optimal tool to provide clinic-level data.

Best Practice Note:
CAHPS Surveys

While a variety of CAHPS survey tools are available, we recommend using the Clinician and Group Survey with Patient Centered Medical Home items, which can be found at:
http://cahps.ahrq.gov/clinician_group/.
We also recommend using the AHRQ guidelines for survey administration available here:
http://www.cahps.ahrq.gov/clinician_group/cgsurvey/fieldingcahps-cgsurveys.pdf

The newest survey version is the 3.0 and involves a 6 month look back rather than 12 months as in the 2.0 version of the CAHPS survey. The version 3.0 went online in 2015. Clinics can use the 2.0 if they wish – however there are fewer questions in the 3.0 version.

Differences between version 2.0 and 3.0 can be found here: http://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf Clinics may choose to use Version 2.0 or 3.0 at their discretion.

To meet 6.C.3, your clinic must calculate the patient survey top box scores and meet the benchmarks on the majority of the domains regarding provider communication, provider rating, follow-up on test results, and practice staff helpfulness. The instructions to calculate your score are below for the most commonly used CAHPS survey, the Clinician and Group. If you use a vendor to administer the survey, you can use the overall domain score.

Domain specific questions:

These are the questions for one adult version of the Clinician and Group surveys. If a practice sees children, they will use the corresponding child focused questions. If a different version of the survey is used, questions may be numbered differently or slightly reworded.

Domain: How Well Providers (or Doctors) Communicate with Patients

Q14- Provider explained things in a way that was easy to understand.
Q15- Provider listened carefully to patient
Q17- Provider gave easy to understand information about health questions or concerns.
Q18- Provider knew important information about patient's medical history
Q19- Provider showed respect for what patient had to say
Q20- Provider spent enough time with patient

Domain: Helpful, Courteous, and Respectful Office Staff

Q24- Clerks and receptionists helpful
Q25- Clerks and receptionists courteous and respectful

Domain: Patients' Rating of the Provider (or Doctor)

Q23- Rating of provider

Domain: Follow up on Test Results

Q22- Someone from provider's office followed up with patient to give results of blood test, x-ray, or other test

Please use the following instructions for calculating the top box score *for each domain* in the survey regardless of the survey version that you are using. Please visit the CAHPS website for more information about how to calculate your domain scores:
https://www.cahpsdatabase.ahrq.gov/files/CGGuidance/Preparing_Analyzing_Data_CG30_2035.pdf

The top box scoring method is the percentage of respondents who chose the most positive score on the response scale (e.g., "Always" on the "Always-Never" scale) for each of the questions the respondent answered within a given domain. For example, in the "Helpful, Courteous, and Respectful Office Staff" domain within the Clinician and Group survey, there are two questions total. If 30 patients answer the first question, and 20 of them choose the most positive response (i.e. always) the proportion for that question is 67%. If 20 patients responded to the second question and 10 of them choose the most positive response (i.e. always), the proportion for that question is 50%. To calculate the domain score, you would take the average of the first and second question, meaning (67 + 50) ÷ 2 = 59. The top box score would therefore be 59% for the "Helpful, Courteous, and Respectful Office Staff" domain.

Note for the Provider Rating domain, the top box score is the percentage of respondents who marked either 9 or 10 on the 1-10 rating scale.

Benchmarks -

To meet 6.C.3, your clinic's top box domain scores must meet or exceed the benchmark in 3 of the 6 domains for the Clinician and Group surveys. Clinics using the health plan survey must meet the benchmark in both domains.

Core CG-CAHPS Domains + PCMH Domain: 2014 Scores

Core CG- CAHPS Domains plus PCMH Domain	Adult Survey (Top Box Score 75th percentile)	Child Survey (Top Box Score 75th percentile)
Getting timely appointments, care, and information	70%	76%
Provider Communication	88%	91%
Helpful, Courteous, and Respectful Office Staff	87%	82%
Follow-Up on Test Results	82%	87%
Provider Rating	87%	87%
Providers Support You in Taking Care of Your (or your child's) Health (PCMH domain)	57%	44%

CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE
Standard 6.D – Communication of Rights, Roles, and Responsibilities

Measure:

> **6.D.1 - PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, complaint, and grievance procedures; roles and responsibilities; and has a system to ensure that each patient or family receives this information at the onset of the care relationship. (5 points)**

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Intent – Information exchange and communication are essential components of patient and family-centered care. This standard is intended to facilitate this exchange between patients, caregivers, and families and providers. Clarifying patient and family roles and responsibilities as part of a care team before or at the time of a patient or family's first visit can be effective towards building long lasting and trusting relationships. Patients and families should understand their new role as the most important member of their health care team, and should be encouraged to partner with their team so that they receive the best possible care. The available evidence shows a strong association between information sharing and the following outcomes: patient empowerment, self-management through better adherence to medications, improved chronic disease control and reduced costs of care.

Documentation Required – At a verification site visit, clinics must be able to produce a copy of the document or educational materials used, and a written policy that has been implemented at the clinic for ensuring patients receive the materials in their language of choice.

Specifications –

Activities that meet this standard include a brochure or handout, tailored to language and literacy levels, which every patient receives upon checking in for their first visit, or that is mailed to them before their visit, and includes:

- Hours of operations and after-hours contact information
- Expectations of patients and their families to prepare for their visits
- Rules, policies, or procedures that every patient should be aware of
- Expected maximum response times for patient requests
- Explanation of health care team roles and responsibilities

Quality Measures
Core and Menu Set Specifications
For PCPCH Standard 2.A

Overview of PCPCH Core and Menu Set Quality Measures

Adult Core Quality Measure Set

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
1	NQF0421	BMI Screening and Follow-up	X		X	47%
2	NQF0028	Tobacco Use: Screening and Cessation Intervention	X		X	93%
3	NQF0509	Reminder System for Mammograms			X	TBD
4	NQF0032	Cervical cancer screening	X			73%
5	OHA State Performance Measure (NQF 0034)	Colorectal cancer screening	X	X		47%
6	OHA State Performance Measure (NQF 0057)	Comprehensive Diabetes Care: Hemoglobin A1c testing		X		86%
7	NQF0575	Comprehensive Diabetes Care: HbA1c control	X			60%
8	OHA State Performance Measure (NQF 0018)	Controlling High Blood Pressure		X		64%

Pediatrics Core Quality Measure Set

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
9	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X		X	43%
10	OHA State Performance Measure (NQF0038)	Childhood Immunization Status	X	X		82%
11	NQF0036	Use of Appropriate Medications for People with Asthma	X			91%
12	OHA State Performance Measure (NQF1399)	Developmental screening in the first 3 years of life		X		50%
13	OHA State Performance Measure (NQF 1392)	Well child care (0 – 15 months)		X		77%
14	NQF 1516	Well child care (3 – 6 years)				74%
15	OHA State Performance Measure (CHIPRA Core Measure #12)	Adolescent well-care (12-21 years)		X		53%

Menu Quality Measure Set

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
16	OHA State Performance Measure (NQF 0418)	Screening for clinical depression		X		25%
17	OHA State Performance Measure (NQF 1517)	Prenatal and Postpartum Care – Prenatal Care Rate		X		69%
18	OHA State Performance Measure (NQF1517)	Prenatal and Postpartum Care – Postpartum Care Rate	X	X		66%
19	OHA State Performance Measure (NQF0002)	Appropriate testing for children with pharyngitis		X		76%
20	NQF0043	Pneumonia vaccination status for older adults				TBD
21	NQF0044	Pneumonia Vaccination				TBD
22	NQF0041	Influenza Immunization				TBD

Menu Quality Measure Set, Continued

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
23	NQF0066, 67,70, 74	Chronic Stable Coronary Disease				NQF 0070, 83%
24	OHA State Performance Measure	Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse		X		13%
25	NQF0061	Comprehensive Diabetes Care: Blood Pressure Control	X			67%
26	NQF0064	Comprehensive Diabetes Care: LCL-C Control	X			40%
27	OHA State Performance Measure (NQF0108)	Follow-up care for children prescribed ADHD medication		X		Initiation: 51% Continuation & Maintenance: 63%
28	OHA State Performance Measure (NQF 1407)	Adolescent immunizations up to date at 13 years old		X		70%
29	OHA State Performance Measure (NQF0063)	Comprehensive Diabetes Care: Lipid LDL-C Screening		X		80%

Note: Any additional adult or pediatric core measure that a practice tracks can be used as a menu set measure.

1. BMI Screening and Follow-up

PCPCH Adult Core Set

NQF0421

Description

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0421
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

47%

2. Tobacco Use: Screening and Cessation Intervention

PCPCH Adult Core Set

NQF0028

Description

Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0028
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

93%

3. Reminder System for Mammograms

PCPCH Adult Core Set

NQF0509

Description

Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0509
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate:
Not established yet.

Clinics that choose to report on quality measures that do not have a benchmark set yet cannot earn 15 points for 2.A.3. A clinic can earn 10 points for reporting on 3 quality measures, but can only earn 15 points if they choose to report on 3 quality measures that have benchmarks established and meet the benchmarks for each measure.

4. Cervical Cancer Screening

PCPCH Adult Core Set

NQF0032

Description

Percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0032
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

73%

5. Colorectal Cancer Screening

PCPCH Adult Core Set

NQF0034

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0034
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark

47%

6. Comprehensive Diabetes Care: Hemoglobin A1c testing

PCPCH Adult Core Set

NQF0057

Description

Percentage of adult patients with diabetes (type 1 or 2) aged 18-75 years receiving one or more HbA1c test(s) per year.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0057
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

86%

7. Comprehensive Diabetes Care: HbA1c control

PCPCH Adult Core Set
NQF0575

Description

The percentage of patients 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0%.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0575
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

60%

8. Controlling High Blood Pressure

PCPCH Adult Core Set
NQF0018

Description

The number of patients 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90).

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0018
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

65%

9. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

PCPCH Pediatric Core Set

NQF0024

Description

Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0024
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

43%

10. Childhood Immunization Status

PCPCH Pediatric Core Set

NQF0038

Description

Percentage of children 2 years of age who had four DtaP/DT, three IPV, one MMR, two H influenza type B, three hepatitis B, one chicken pox vaccine (VZV), four pneumococcal conjugate vaccines, two hepatitis A vaccines, two or three rotavirus, and two influenza by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates. Only one combination rate is required for PCPCH reporting.

Specifications

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 24-29 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

82%

11. Use of Appropriate Medications for People with Asthma

PCPCH Pediatric Core Set

NQF0036

Description

The measure assesses the percentage of members 5-64 years of age during the measurement year who were identified as having moderate to severe persistent asthma and who were appropriately prescribed medication during the measurement year.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0036
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

91% (combined rate)

12. Developmental screening in the first 3 years of life

PCPCH Pediatric Core Set

NQF1399

Description

The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Specifications

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 66-70 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

For more information about development screening please refer to:
http://www.oregon.gov/oha/analytics/CCOData/Developmental%20Screening%20Guidance%20Document%20--%20revised%20Dec%202014.pdf

Benchmark rate

50%

13. Well-Child Care (0 – 15 months)

PCPCH Pediatric Core Set
CHIPRA Core Measure #10

Description

The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

Specifications

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 76-78 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

77%

14. Well-Child Care (3 – 6 years)

PCPCH Pediatric Core Set

CHIPRA Core Measure #11

Description

The percentage of members 3–6 years of age who received one or more well-child visits during the measurement year.

Specifications

To access the technical specifications for this measure:

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 79-80 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

74%

15. Adolescent Well-Care (12-21 years)

PCPCH Pediatric Core Set

CHIPRA Core Measure #12

Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Specifications

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 81-83 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

53%

16. Screening for Clinical Depression

PCPCH Menu Set
NQF0418

Description

Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool and follow-up plan documented.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0418
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark

25%

17. Prenatal Care and Postpartum Care: Prenatal Care Rate

PCPCH Menu Set
NQF 1517

Description

The percentage of deliveries that had a prenatal visit in the first trimester of pregnancy.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/1517
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

69%

18. Prenatal and Postpartum Care: Postpartum Care Rate

PCPCH Menu Set
NQF 1517

Description

The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/1517
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

66%

19. Appropriate testing for children with pharyngitis

PCPCH Menu Set
NQF0002

Description

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Specifications

1) Visit the National Quality Forum website.

   Go to http://www.qualityforum.org/QPS/0002

2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

76%

20. Pneumonia vaccination status for older adults

PCPCH Menu Set
NQF0043

Description

Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0043
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

Not established yet.

Clinics that choose to report on quality measures that do not have a benchmark set yet cannot earn 15 points for 2.A.3. A clinic can earn 10 points for reporting on 3 quality measures, but can only earn 15 points if they choose to report on 3 quality measures that have benchmarks established and meet the benchmarks for each measure.

21. Pneumonia Vaccination

PCPCH Menu Set
NQF0044

Description

Percentage of patients who ever received a pneumococcal vaccination.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0044
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

Not established yet.

Clinics that choose to report on quality measures that do not have a benchmark set yet cannot earn 15 points for 2.A.3. A clinic can earn 10 points for reporting on 3 quality measures, but can only earn 15 points if they choose to report on 3 quality measures that have benchmarks established and meet the benchmarks for each measure.

22. Influenza Immunization

PCPCH Menu Set
NQF0041

Description

Percentage of patients aged 6 months and older seen for a visit between the measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0041
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

Not established yet.

Clinics that choose to report on quality measures that do not have a benchmark set yet cannot earn 15 points for 2.A.3. A clinic can earn 10 points for reporting on 3 quality measures, but can only earn 15 points if they choose to report on 3 quality measures that have benchmarks established and meet the benchmarks for each measure.

23. Chronic Stable Coronary Disease

PCPCH Menu Set

NOTE: Practices can report on one of any of the following four measures. Please indicate on the application in the "Other" section which measure you are reporting by NQF number.

NQF0066, 67, 70, 74

Description

NQF 0066

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes or a current or prior LVEF <40% who were prescribed ACE inhibitor or ARB therapy

NQF 0067

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel

NQF 0070

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy

NQF 0074

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result >=100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0066
   http://www.qualityforum.org/QPS/0067
   http://www.qualityforum.org/QPS/0070
   http://www.qualityforum.org/QPS/0074

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate NQF0070
83%
Not established yet for NQF 0066, 0067 or 0074

Clinics that choose to report on quality measures that do not have a benchmark set yet cannot earn 15 points for 2.A.3. A clinic can earn 10 points for reporting on 3 quality measures, but can only earn 15 points if they choose to report on 3 quality measures that have benchmarks established and meet the benchmarks for each measure.

24. Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse

PCPCH Menu Set
OHA State Performance Measure

Description

Percentage of members age 18 years or older that received a qualifying outpatient service.

Specifications

To access the technical specifications for this measure:

1) Visit the Oregon Health Authority – State Performance Measures website. Go to http://www.oregon.gov/oha/analytics/CCOData/Alcohol%20and%20Drug%20Misuse%20(SBIRT)%20-%202015.pdf

2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

For more information about SBIRT, please go to: http://www.oregon.gov/oha/analytics/CCOData/SBIRT%20Guidance%20Document%20--%20revised%20Dec%202014.pdf

Benchmark rate

13%

25. Comprehensive Diabetes Care: Blood Pressure Control

PCPCH Menu Set

NQF0061

Description

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg during the measurement year.

Specifications

To access the technical specifications for this measure:

5) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0061
6) Print out the specifications for the quality measures you are planning to report on.
7) Calculate your clinic's data according to the specifications.
8) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

67%

26. Comprehensive Diabetes Care: LDL-C Control

PCPCH Menu Set

NQF0064

Description

The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent LDL-C test is <100 mg/dL during the measurement year.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0064
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

40%

27. Follow-up care for children prescribed ADHD medication

PCPCH Menu Set
NQF0108

Description

a. Initiation Phase: Percentage of children 6 - 12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for an ADHD medication and who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.

b. Continuation and Maintenance (C&M) Phase: Percentage of children 6 - 12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who in addition to the visit in the Initiation Phase had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ends.

Specifications

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 104-109 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

Initiation: 51%
Continuation & Maintenance: 63%

28. Adolescent immunizations up to date at 13 years old

PCPCH Menu Set

CHIPRA Core Measure #6

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Specifications

1) Visit the CMS CHIPRA website.
   Go to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf
   See page 30-32 of PDF.
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications found in the document except that clinics must calculate and report on entire population and not only their Medicaid patients.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

70%

29. Comprehensive Diabetes Care: Lipid LDL-C Screening profile

PCPCH Menu Set
NQF0063

Description

Percentage of adult patients with diabetes (type 1 and type 2) aged 18-75 years who received an LDL-C test.

Specifications

To access the technical specifications for this measure:

1) Visit the National Quality Forum website.
   Go to http://www.qualityforum.org/QPS/0063
2) Print out the specifications for the quality measures you are planning to report on.
3) Calculate your clinic's data according to the specifications.
4) Keep the specifications you are using and your raw data summaries along with your other PCPCH application documentation.

Benchmark rate

80%

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