Oregon Health Authority

Patient-Centered Primary Care Home Program

2014 Recognition Criteria

www.PrimaryCareHome.oregon.gov

Email: PCPCH@state.or.us

Technical Specifications and Reporting Guide
(TA Guide)

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Oregon Patient-Centered Primary Care Home 2014 Recognition Criteria Technical Specifications and Reporting Guide (TA Guide)

Introduction

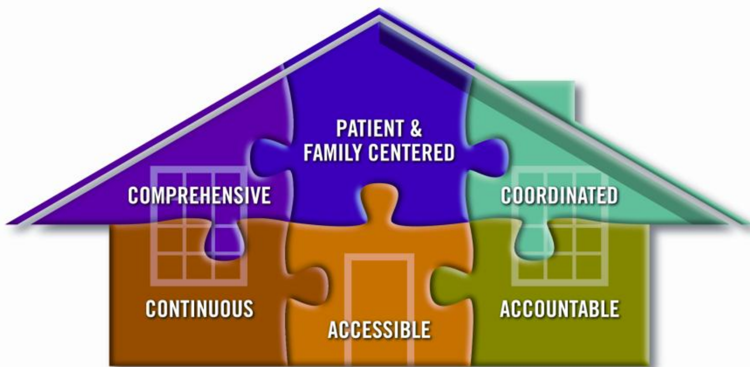
Thank you for your interest in becoming recognized as a Patient-Centered Primary Care Home (PCPCH). As a recognized primary care home, your practice can be part of Oregon's vision for better health and lower costs for all Oregonians.

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.

The ultimate goal is that 75 percent of all Oregonians will have access to a primary care home by 2015.

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.

Background

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 2014 criteria are effective on January 1, 2014. Any clinics applying for PCPCH recognition on or after January 1, 2014 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 provides 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.

New to the 2014 TA Guide are **"Best Practice Notes"** that 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 model of care (also known as the medical home) 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]

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

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

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

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 filled out 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 three different levels, or tiers, depending on the criteria they meet. There are 10 "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 10 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.

For a practice to become recognized as a primary care home, it must meet the following point thresholds:

Tier 1: 30 - 60 points and all 10 must-pass measures
Tier 2: 65 - 125 points and all 10 must-pass measures
Tier 3: 130 or more points and all 10 must-pass measures

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 Primary Care Home

Recognition Renewal Requirements

Your 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 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 be a variety of payment incentives available from the health plans that your clinic contracts with. Please visit the PCPCH program website Payment Incentives page for information on current opportunities.

On-Site Verification

OHA will conduct a verification process on a select percentage of recognized clinics. When a clinic is selected for an on-site verification, 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 recommended that you prepare a binder of documentation to support the application attestation. A documentation binder (paper or electronic) 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 to schedule an appointment at least 30 days prior to the intended site visit date.

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.

Please visit the Institute website where you can search for tools and resources by PCPCH standard or topic area, and learn about upcoming training opportunities. Learn more at www.pcpci.org.

NCQA and Oregon PCPCH Recognition

Some practices have already, or are in the process of, pursuing Patient Centered Medical Home (PCMH) recognition 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 NCQA-recognized has the option to use their recognition to bypass attesting to some of the PCPCH standards. Depending on the version of NCQA recognition that was achieved, clinics seeking Oregon PCPCH recognition must attest to and submit additional information as outlined in the tables below. OHA will then recognize PCMH sites at the same level that NCQA has recognized the site. NCQA-recognized clinics that choose to use their recognition to bypass attesting to some PCPCH standards must also submit documentation of their recognition by email to PCPCH@state.or.us.

A clinic that is already NCQA recognized also has the option to submit an entire PCPCH application. The clinic will be recognized according to the scoring system outlined in this guide.

Oregon PCPCH Program and 2008 NCQA Recognition Requirements

For practices that are recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home under the 2008 NCQA Criteria

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2008 Level 1 NCQA PCMH Recognition	Attests and provides evidence of recognition to OHA	N/A	N/A
2008 Level 2 NCQA Recognition	N/A	Attests and provides evidence of recognition to OHA	N/A
2008 Level 3 NCQA Recognition	N/A	N/A	Attests and provides evidence of recognition to OHA
PCPCH Standard 2.A) Performance & Clinical Quality	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
PCPCH Standard 3.C) Mental Health, Substance Abuse, & Developmental Services	Attests to meeting must pass measure 3.C.0	Attests to meeting measure 3.C.2	Attests to meeting measure 3.C.3
PCPCH Standard 5.F) End of Life Planning	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

Oregon PCPCH Program and 2011 NCQA Recognition Requirements

For practices that are recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home under the 2011 NCQA Criteria

Requirement	Oregon PCPCH Tier Recognition		
	Tier 1	Tier 2	Tier 3
2011 Level 1 NCQA PCMH Recognition	Attests and provides evidence of recognition to OHA	N/A	N/A
2011 Level 2 NCQA Recognition	N/A	Attests and provides evidence of recognition to OHA	N/A
2011 Level 3 NCQA Recognition	N/A	N/A	Attests and provides evidence of recognition to OHA
PCPCH Standard 2.A) Performance & Clinical Quality	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
PCPCH Standard 5.F) End of Life Planning	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

The 10 Must-Pass Criteria for PCPCH Recognition

Standard	Criterion
Standard 1.C Telephone and Electronic Access	1.C.0 PCPCH provides continuous access to clinical advice by telephone.
Standard 2.A	2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.
Standard 3.B Medical Services	3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Patient education and self-management support.
Standard 3.C Mental Health, Substance Abuse, & Developmental Services	3.C.0 PCPCH has a screening strategy for mental health, substance use, or developmental conditions and documents on-site and local referral resources.
Standard 4.A Personal Clinician Assignment	4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)
Standard 4.B Personal Clinician Continuity	4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)
Standard 4.C Organization of Clinical Information	4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.
Standard 4.E Specialized Care Setting Transitions	4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
Standard 5.F End of Life Planning	5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.
Standard 6.A Language/Cultural Interpretation	6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice

(D) – Data submission required with application.

Questions?

We are here to help. Please contact the PCPCH 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 – Attestation only. 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 satisfaction 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 30 patients each year, and must include all received survey results in reported data.

- Patients must be included from all provider panels 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.

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.)
- Include patients who have had at least one visit in the target time frame.
- 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.
- The recommended, or target, response rate is 40 percent.
- 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://www.cahps.ahrq.gov/surveysguidance.htm

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 perform at or above the benchmark levels on a single access to care survey of at least 30 patients. If you use a vendor to administer the survey, you can use the overall domain scores. 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.

Numerator: Number of survey respondents who chose the most positive score on the response scale for all of the questions above (e.g., "Always" on the "Always-Never" scale). For example, if 30 patients answer the survey and 20 of them choose the most positive response to all questions, then the numerator would be 20.

Denominator: Total number of survey participants that complete all of the above questions. In this example, it would be 30.

Benchmarks – To meet measure 1.A.3, clinics must use the access to care questions from one of the CAHPS survey tools and meet the benchmarks listed below, depending on the survey tool used.

CAHPS Access to Care Benchmarks[1]

CAHPS Survey Tool	Survey Version	Domain	Benchmark (%)
Clinician & Group	Adult	Getting Timely Appointments, Care, and Information	69%
Clinician & Group	Child	Getting Timely Appointments, Care, and Information	75%
Health Plans & Systems	Adult	Getting Needed Care	54%
Health Plans & Systems	Adult	Getting Care Quickly	59%

[1] These benchmarks are from data previously reported by HRSA.

Health Plans & Systems	Child	Getting Needed Care	59%
Health Plans & Systems	Child	Getting Care Quickly	75%

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 – Attestation only. 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.

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

Measures:

> **1.C.0 - PCPCH provides continuous access to clinical advice by telephone. (Must-Pass)**
>
> **1.C.1 - When patients receive clinical advice via telephone, these telephone encounters (including after-hours encounters) are documented in the patient's medical record. (5 points)**

This is a must-pass standard. Clinics must, at a minimum, meet measure 1.C.0 to qualify for PCPCH recognition at any level. Clinics can also receive points for completing 1.C.1, but this is not required for recognition.

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 – Attestation only. 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.

To meet 1.C.1, the clinic must have documented policy and procedures, including provider expectations for workflow and EHR access, to ensure all after hours telephone encounters are documented in EHR 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.C.0.). Information about calls to the nurse advice line are faxed to the clinic each day and input into patients' medical records (1.C.1).

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

To ensure patients can access clinical advice when needed, it's important that your patients are aware of this service, and can easily access the after-hours phone number.
Clinics should also ensure that qualified/certified telephonic interpreter services, TTY, and/or other electronic means of communication are available to patients, caregivers and family members who call for clinical advice.

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

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 – Attestation only. 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.3 - Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request. (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 - 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 – Attestation only. At a verification site visit, clinics should be able to produce a completed Meaningful Use worksheet for one of the Meaningful Use measures listed in the specifications section below.

Specifications –
Clinics must meet the specifications established by CMS for the EHR Meaningful Use Incentive Program. A clinic that meets any of the following Meaningful Use measures will qualify for PCPCH Measure 1.E.3:

- Stage 1 Meaningful Use core measure #12
- Stage 1 Meaningful Use menu measure #5
- Stage 2 Meaningful Use measure #7

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

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[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

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.3:

- An electronic portal (e.g. MyChart) 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.3:

- 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.1 - PCPCH tracks the time to completion for prescription refills. (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 - The focus of this standard is on the communication and engagement between the clinic and the pharmacy. 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 – Attestation only. At a verification site visit, clinics should be able to produce a log for tracking time to completion, the results of a chart review, or an electronic medical record report that includes tracking time to completion.

Specifications -
The easiest method of calculation for this measure would be to utilize an EHR system that could calculate the average time between the initial request from the pharmacy to the clinic for a medication refill and the successful completion of that request from the clinic to send the authorized refill back to the pharmacy. If an EHR report is not available, clinics can conduct a chart review. A chart review or EHR report must include at least 30 patients and be conducted over a 12 month reporting period.

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

[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.

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.2 - PCPCH tracks and reports to the OHA two measures from the 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.

Documentation Required - Data submission required with application for 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 102. 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.

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 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 24-month period prior to application submission.

> **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

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.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 102.

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

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 a benchmark set.

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 - Attestation only. 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.partnerforqualitycare.org/

- Reporting clinic-level performance data to a federal or state agency or initiative such as 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 - Attestation only. 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 - Attestation only. 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.
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

[1] Medicare Payment Advisory Commission (MEdpAC) (2008) Report to Congress: Reforming the Delivery System, June, 2008. http://www.medpac.gov/documents/june08_EntireReport.pdf

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 -
Examples of activities meeting the intent of **2.D.1** would be:

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

Examples of activities not meeting the intent of 2.D.1 would be:

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

Examples of activities meeting the intent of **2.D.2** include the following:

- 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.
- The progress of each improvement project

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

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.

Examples of activities 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.

Examples of activities meeting the intent of **2.D.3** would be:

- 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 – Attestation only. 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 http://www.qualitymeasures.ahrq.gov/content.aspx?id=35186
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 hospitalized patients discharged from an inpatient facility to home or any other site of care for whom 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.

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

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 91 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 on their entire population of active patients age 18 and older, not only their Medicaid 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: Active patients for whom a transition record was received by the PCPCH and received a phone call to schedule an in-person follow-up visit within 24 hours of discharge.

Denominator: All active patients known to be discharged 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.

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 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 <u>except</u> 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 at least 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 – Attestation only. 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]

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)
- 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

[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/

- 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 21 services on the table that apply to the population. The denominator would be 21, and in order to meet 3.A.3, the clinic would need to ensure the provision of at least 19 of these services (19 ÷ 21 = 90%).

Recommended Service	Source	Sub-population
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	Men age 45-79, Women age 55-79
Autism Screening	BF	Children
Bacteriuria Screening	USPSTF	Pregnant Women
BP Screening	USPSTF	Children, 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 counseling1	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 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

[1] Screening methods described by the One Key Question Initiative would be adequate for this service www.onekeyquestion.org

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 women 60-65
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; 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 – Attestation only. 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 diseases 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)
- 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.

Best Practice Note:
Providing Comprehensive Care

Standard 3.B is a must-pass standard that outlines the basic requirements for adequate functioning as a primary care home. Ideally, primary care homes would be performing at a higher capacity than outlined here. For example, prescribing authority is another critical function, and primary care homes should strive to manage all of their patients' medicines more comprehensively, which may require a pharmacist or protocols approved by a pharmacist.

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 for patients taking five or more medications for two or more chronic medical conditions:

(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 3: COMPREHENSIVE WHOLE-PERSON CARE
Standard 3.C – Mental Health, Substance Abuse, & Developmental Services

Measures: (Check all that apply)

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

3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, or developmental providers including a mechanism for co-management as needed. (10 Points)

3.C.3 - PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental 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 additional points if they meet 3.C.2 and/or 3.C.3. In total, 25 points are available for this standard because points can be awarded for both 3.C.2 and 3.C.3 simultaneously.

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 – Attestation only. 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/or 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, or 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, substance use, or developmental condition. 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 or developmental, behavioral or social delays for patients requiring specialty care.

3.C.0 Examples -

Practice strategies meeting the intent of measure 3.C.O would include completed examples of at least one 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 autism screening tool giving at 18 and 24 months). The clinic also must use an up-to-date list of referral sources for parents of children that have positive screens.
- Brief screening tools used routinely to assess for depression or another mental health condition commonly seen in the practice's patient population. These screening tools should be universal (i.e. every patient, regardless of symptoms). Many clinics screen for depression using the Patient Health Questionnaire[1] (PHQ) screening tools for assessing depression and anxiety.
- Additional standardized evidence-based screening tools administered routinely such as the AUDIT, DAST, and CRAFFT (for adolescents), GAD, and the CAGE.
- Patient intake, history, or screening forms, given to every patient on at least an annual basis, that document assessment of alcohol or substance use, and examples of management or referral for patients with positive screens. Many clinics use Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based process, and this would meet the intent of this measure[2].

Note: Using new patient intake or history forms updated routinely that document assessment of depression, alcohol and substance use, or developmental conditions would be acceptable to meet 3.C.0, but is not considered best practice because it is not evidence-based screening. Please see the Best Practice box below for more information.

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

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

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 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 of these conditions persist in adulthood.

3.C.2 and 3.C.3 Specifications -

Clinics meeting the intent of measures 3.C.2 and 3.C.3 must demonstrate evidence of collaborative provider relationships and care coordination for patients receiving either specialty or on-site care for a mental health, substance use, or developmental, behavioral or social delays.

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.

Clinics meeting 3.C.3 must have a co-located, on-site provider for mental or behavioral health, substance use, or developmental, behavioral or social delays. Rural clinics with critical access shortages can achieve "virtual" co-location with the use of telemedicine or telepsychiatry, as long as all other conditions are met.

Examples -

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

- Names of specialty providers and 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.
- Examples of regular two-way communication with these providers in patient charts demonstrating active coordination of patient care.

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

- Co-location of a specialty mental health provider (e.g. psychiatrist, psychologist, counselor, social worker, etc.) in the primary care home and demonstration of collaboration or co-management as in 3.C.2.
- Group counseling sessions for behavioral health concerns or substance abuse issues.
- Use of a shared electronic medical record with a co-located mental health, substance abuse or developmental provider to facilitate coordination and integration of patient care.
- A behaviorist embedded in the primary care team that is available for warm hand-offs, curbside consultation, and brief behavioral interventions. A behaviorist is a mental health professional who is competent in assessing and addressing psychosocial aspects of health conditions. This could be a licensed therapist or counselor, a social worker, a psychiatrist nurse practitioner, a psychologist, or a psychiatrist.

Activities not meeting the intent of 3.C.2 or 3.C.3 include:

- Faxing chart notes between providers, without evidence in the medical record of two way communication between clinicians and specialty providers regarding co-management of patients' plan of care.

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 – Attestation only. 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, diet, physical activity, interpersonal violence,

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.

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 could include documentation of the following types of activities in patient records:

- 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/prevention/SBIRT/index.aspx. Also see www.sbirtoregon.org

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

Measures:

> **3.E.1 - PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services. (5 points)**
>
> **3.E.2 - PCPCH tracks the number of unique patients who were sent appropriate reminders. (10 points)**
>
> **3.E.3 - Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventive/follow-up 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 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 – Attestation only. At a verification site visit, a clinic should be able to produce a log, database, or other file of patients who need reminders and examples of actual correspondence with patients to remind of needed services.

Specifications -
To meet 3.E.1 and 3.E.2, the clinic must have a log, database, or other file that shows 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 patient, and dates of completed service.

To meet 3.E.2, the clinic must also have documentation showing the number of unique patients sent each reminder.

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.

To meet 3.E.3, clinics must meet the requirements of one of the following CMS EHR Incentive Program Meaningful Use measures. A clinic that meets any of the following Meaningful Use measures will qualify for PCPCH measure 3.E.3:

- Meaningful Use Stage 1 Menu Set Measure 4
- Meaningful Use Stage 2 Core Measure 12

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 –

Activities meeting the intent of this standard:

- Clinic uses a log or file that includes 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 HgA1c in the last 3 months to ask them to come in for a lab draw.

Activities not meeting the intent of this standard:

- Posting signs in the clinic, or materials on the website, about 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.

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

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[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.

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 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.

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, behaviorist, community health worker) and contain up to two full

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[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.

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 continuity calculations, then patients must be routinely notified/informed of which team they belong.

[1] 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/B/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. 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.

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[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:** 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 as well.*

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 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.

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, behaviorist, 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**

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[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 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/B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf

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% improvement in reported scores over a period of at least one year, or ≥ 5% 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.

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 – Attestation only. At a verification site visit, clinics that are using a "Meaningful Use" certified electronic health record would not need to provide additional documentation. If the clinic is not, 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 -
Examples of strategies meeting the intent of 4.C.0 include:

- 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 – Attestation only. 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 -
Activities meeting the intent of 4.D.3 include:

- Arrangement with usual hospital, emergency and specialty care providers to have real-time electronic access to their 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.

Activities not meeting the intent of 4.D.3:
- Participation in immunization registry
- Electronic reporting of laboratory tests to public health department
- Secure 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 – Attestation only. 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
- Process and performance expectations for communication at the time of hospital admission

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[1] PCPCHs that have clinicians providing their own hospital care 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 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 – Attestation only. 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 -
Activities 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.
- Locums providers are available when other providers are unavailable.

Activities 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

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. (5 points)**
>
> **4.G.2 - PCPCH tracks the percentage of patients whose medication regimen is reconciled. (10 points)**
>
> **4.G.3 - Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH performs medication reconciliation for patients in transition of 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 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.

Documentation Required – Attestation only. At a verification site visit the clinic must be able to provide examples in the medical record that demonstrate medication reconciliation, a policy/procedure to ensure routine medication reconciliation, and any forms/templates used for this process.

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

To meet 4.G.3, clinics must meet the requirements of one of the following CMS EHR Incentive Program Meaningful Use measures. A clinic that meets any of the following Meaningful Use measures qualifies for PCPCH measure 4.G.3:

- 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.

Best Practice Note:
Preventing Medication Errors

An evidence-based best practice for medication reconciliation
includes the following elements[1]:

- Defined steps for the reconciliation process: (a) verifying the lists of medications, vitamins, nutritional supplements, over-the-counter drugs, and vaccines; (b) clarifying that the medications and dosages are appropriate; and (c) reconciling and documenting any changes.
- Defined roles, responsibilities, and timeframes for the process: (a) evaluating existing processes; (b) identifying a standard location in the patient chart where the medication history is kept; (c) determining who performs and documents the reconciliation, the process by which that is done, (d) determining timeframes for performing reconciliation and resolving variances, and (e) documenting medication changes.
- Standardized medication forms
- Patient and family education as a routine part of complex medication management, e.g., a process where patients taking more than 5 medications bring all of their medications to every visit to ensure the most accurate reconciliation process.

[1] Adapted from: Patient Safety and Quality, An Evidence-Based Handbook for Nurses, Edited by Ronda G Hughes, PhD, MHS, RN., Rockville (MD): Agency for Healthcare Research and Quality (US); April 2008., Publication No.: 08-0043, (Chapter 38, author is Jane H. Barnsteiner); the link is: http://www.ncbi.nlm.nih.gov/books/NBK2648/

Also please see the North Carolina Center for Hospital Quality and Patient Safety© *Medication Safety Reconciliation Toolkit* at: http://www.ncqualitycenter.org/wp-content/uploads/2013/01/MRToolkit.pdf

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

Measures: (Check all that apply)

5.A.1a - PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population, including the identification of sub-populations. (5 points)

5.A.1b - PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information. (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 – In order to coordinate and manage care, a primary care home should be able to produce and track basic information about its patient population. In addition, clinics should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease or health care need.

Documentation Required – Attestation only. At a verification site visit, the clinic must be able to produce data reports for the clinic's patient population for 5.A.1a (e.g., age, gender, diagnosis code, medication, patient registry), and data reports of sub-populations for 5.A.1b (e.g., mammograms, well-child appointments, HbA1c, lists of patients being follow up after emergency room discharge). For 5.A.1b, the clinic must also be able to produce examples of how the clinic tracks and proactively manages patients with specific conditions or health care needs.

Specifications –
Measure 5.A.1b requires a practice to demonstrate the use of population-based data generated in 5.A.1a 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.

Examples -

Clinics meeting the intent of 5.A.1a should be able to demonstrate examples of the following kinds of activities:

- PCPCH produces current data regarding its patient population and can sort this information by subgroups. In order to do this, a practice must have an electronic practice management system, electronic health record (EHR), or an actively maintained patient registry with the capability to generate lists of patients.
- PCPCH queries its practice management system or EHR to produce an age or gender specific list of patients (e.g. children under two, women over 50).
- PCPCH queries its practice management system or EHR to produce a list of all patients with a certain diagnosis (e.g. asthma or diabetes) or who are prescribed a particular medication (e.g. depo provera).
- PCPCH uses run charts to display population-level data including sub-populations of patients.
- 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].

Examples of activities meeting the intent of 5.A.1b:

- PCPCH uses a list of patients to generate patient reminders 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)

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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

- 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, obese BMI, or abnormal screening tests) to target health promotion activities or needed follow up.
- PCPCH implements a "risk stratification" strategy (see below) 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.

Examples of activities not meeting the intent of 5.A.1b:

- 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, 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.

Best Practice Note:
Risk Stratification

Stratification is a statistics 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.
For more information, please visit
http://www.aafp.org/practice-management/pcmh/initiatives/cpci/rscm.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 – Attestation only. 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 scorecard 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

[1] www.cms.gov/EHRIncentivePrograms/

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.

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

Measures: (Check all that apply)

5.C.1 - PCPCH assigns individual responsibility for care coordination and tells each patient or family the name of the team member responsible for coordinating his or her care. (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 – Attestation only. 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 -
Measure 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. All 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 of who is responsible for their coordination needs.

Measure 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.

Measure 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
- action plans for exacerbations of chronic illness

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

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 -

A clinic could demonstrate meeting **Measure 5.C.1** through the following kinds of activities:

- 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

A clinic could demonstrate meeting **5.C.2** through the following kinds of activities:

- 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)

A clinic could demonstrate meeting **5.C.3** through the following kinds of activities:

- 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.

Best Practice Note:
Developing Patient-Centered Care Plans

Primary care homes should aim to provide whole person care, rather than simply focusing on "sick care" or "organ/disease specific care" as has been traditionally done. Instead, a care plan should be developed and directed in conjunction with the patient, should be patient rather than physician/provider-directed, and should function as a "living document" that changes as the patient's goals change over time.

For more information please watch the Patient-Centered Primary Care Institute webinar "Care Plans – Best Practices for Development and Implementation" at: http://www.pcpci.org/resources/webinars/care-plans-best-practices-development-and-implementation

Pediatric Shared Care Plan examples can also be found at http://www.pcpci.org/sites/default/files/resources/Pediatric%20Shared%20Care%20Plan%20Examples.pdf

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 – Attestation only. 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 -
Clinics could demonstrate meeting the intent of 5.D.1 through the following kinds of activities:

- 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.

The following activities would not meet 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 – Attestation only. 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 – Attestation only. 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 -

Activities meeting the intent of **5.F.0** could include:

- 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

Activities meeting the intent **of 5.F.1** could include:

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

Activities not meeting the intent of **5.F.1** include:

- 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 – Attestation only. 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. Interpretation services should be

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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

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

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.

Examples -
The following kinds of activities would meet the intent of this standard:

- use of bilingual staff to communicate with patients or family members in their language of choice throughout their entire office visit and/or 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.
- 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 (for 6.A.1).

The following activities would not meet the intent of 6.A.0:

- Routine use of patient family members to act as interpreters for non-English speaking patients.
- Interpreter services or employees acting as translators available at 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 during the times when the employee(s) or services are unavailable.

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

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: http://www.oregon.gov/oha/oei/pages/intrprtr/overview.aspx for more information.
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 – Attestation only. 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 -

Clinics meeting the intent of 6.B would be able to provide examples of the following types of activities:

- 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.1 - PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools. (5 points)**
>
> **6.C.2 - PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. The patient survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness. (10 points)**
>
> **6.C.3 - PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness. (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 – 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 – Attestation only. 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.1 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 questions (below) are recommended but not required.
- Clinics must obtain survey results for a minimum of 30 patients each year, and must include all received survey results in reported data.
- Patients should be included from all provider panels 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.

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.)
- Include patients who have had at least one visit in the target time frame.
- 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.
- The recommended, or target, response rate is 40 percent.
- 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 6.C.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 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.1 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://www.cahps.ahrq.gov/surveysguidance.htm

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

To meet 6.C.3, your clinic must calculate the patient survey scores and meet the benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness. The instructions to calculate your score are below for the most commonly used 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.

1. 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

2. Helpful, Courteous, and Respectful Office Staff
   Q24- Clerks and receptionists helpful
   Q25- Clerks and receptionists courteous and respectful

3. Patients' Rating of the Provider (or Doctor)
   Q23- Rating of provider

4. 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 numerator and denominator *for each domain* in the survey regardless of the survey version that you are using:

Numerator: Number of survey respondents who chose the most positive score on the response scale for ALL of the questions within a given domain (e.g., "Always" on the "Always-Never" scale, or "10" on "0-10" scale). For example, in the "Helpful, Courteous, and Respectful Office Staff" domain within the Clinician and Group survey, there are two questions total. If you survey 30 patients and 20 of them choose the most positive response to both questions in that section, then the numerator for that domain would be 40 (20 x 2).

Denominator: Total number of survey responses for ALL of the questions in a given domain (e.g., "Always" on the "Always-Never" scale, or "10" on "0-10" scale). For example, in the "Helpful, Courteous, and Respectful Office Staff" domain within the Clinician and Group survey, there are two questions total. If you survey 30 patients and

each one responds to both questions in that section, then the denominator for that domain would be 60 (30 x 2).

Benchmarks -

To meet 6.C.3, your clinic's scores must meet or exceed the benchmark ((numerator ÷ denominator) X 100) in 3 of the 4 domains for the Clinician and Group surveys. Clinics using the health plan survey must meet the benchmark in both domains.

CAHPS Survey Tool	Survey Version	Domain	Benchmark (%)
Clinician & Group	Adult[1]	How Well Doctors Communicate With Patients	93%
		Helpful, Courteous, and Respectful Office Staff	95%
		Follow-up on Test Results	93%
		Patients' Rating of the Doctor	85%
Clinician & Group	Child	How Well Doctors Communicate With Patients	89%
		Helpful, Courteous, and Respectful Office Staff	83%
		Follow-up on Test Results	83%
		Patients' Rating of the Doctor	85%
Health Plans & Systems	Adult[2]	How Well Doctors Communicate	72%
		Overall Rating of personal doctor	65%
Health Plans & Systems	Child[3]	How Well a Child's Doctors Communicate	77%
		Overall Rating of a child's personal doctor	72%

[1] Any of the Adult survey versions.
[2] Ibid.
[3] Any of the Child survey versions.

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, 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 – Attestation only. 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		TBD
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[1]

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
16	OHA State Performance Measure (NQF 0418)	Screening for clinical depression		X		TBD
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
23	NQF0066, 67,70, 74	Chronic Stable Coronary Disease				NQF 0070, 83%

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

Menu Quality Measure Set, Continued[1]

Measure #	Source	Measure #	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
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%

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

General Measurement Definitions/Concepts

Adult: Unless otherwise noted, measures for adults include patients that are 18 years or older by the end of the measurement year.

Medical Visit: A face to face encounter with a PCP-type provider in the practice (ie. MD, NP, PA, DO, ND). Relevant CPT codes include 99201-99205, 99212-99215, 99241-99245, 99254-99355, 99385-99387, 99395-99397, 99401-99404.

Measurement Year: 12 months from report-run date.

Presentation of Codes*:* Unless otherwise noted, codes are stated to the minimum specificity required. For example, if a three digit code is listed, it is valid as a three-, four- or five-digit code. When necessary, a code may be specified with an "x" which represents a required digit. For example ICD-9 CM diagnosis code 640.0x means that a fifth digit is required, but the fifth digit could be any number allowed by the coding manual.

Patient Selection: Unless otherwise noted, only include patients in the denominator when they have had at least one medical visit during the reporting year for preventive measures and at least two medical visits for chronic disease measures. These visits can be with any provider (does not have to be the PCP) but should be at the practice site.

Problem Identification: Look for diagnoses within a patients active Problem List and within visits/encounters within the last two years. In general, if I problem is identified only in visits (and is not on the problem list), it is reasonable to look only for patients with 2 or more encounters with that diagnosis during the reporting period.

Chart Review/Audit Process

It is possible to collect this data by manual chart review of paper or electronic charts. To do a chart review to assess performance, clinics should draw a randomly selected sample of at least **30 patients** that meet the criteria of the denominator from their practice. If during chart review, it is determined that a patient does not belong in the sample (e.g. meets one of the exclusion criteria or is a dental-only patient), replace that patient in the sample with another randomly drawn patient that meets the criteria of the denominator. If clinics do not have 30 patients that meet the denominator criteria, please contact the PCPCH Program at PCPCH@state.or.us to discuss your options.

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

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.

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/CCOData/Developmental%20Screening%20Guidance%20Document%20(July%202013).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 <u>except</u> 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 18 years and older screened for clinical depression using a 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
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.

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

This measure describes the percentage of patients who were diagnosed with pharyngitis, prescribed an antibiotic, and who received a group A streptococcus test for the episode.

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 113-117 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

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/CCOData/Alcohol%20and%20Drug%20Misuse%20(SBIRT)%20-%20FINAL.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/CCOData/SBIRT%20Guidance%20Document%20(July%202013).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%

Glossary/Definitions[1]

Administrative data collection
Data that is collected for the eligible population using administrative data sources such as registries or transactional databases such as claims and encounters.

CMS
Centers for Medicare and Medicaid Services

CHIPRA
Children's Health Insurance Program Reauthorization Act

Eligible Population
Individuals that satisfy specified criteria.

Measure steward
An organization responsible for maintaining a particular measure or measure set. Responsibilities include updating the codes that are tied to the technical specifications and adjusting measures as the clinical evidence changes.

Mental Health practitioner
A practitioner who provides mental health service and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry or if not certified who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the State of practice.
- An individual who is licensed as a psychologist in his/her State of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of
- Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the State of practice.

[1] Adapted from the CHIPRA Initial Core Set Technical Specifications Manual 2011, available: https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/CHIPRACoreSetTechManual.pdf

- A registered nurse who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist or who has a master's degree in nursing with a specialization in psychiatric/mental; health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the State of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the State of practice or if licensure or certification is not required by the State of practice, who is eligible for clinical membership in the American Association of Marriage and Family Therapy.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the State of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors.

OB/GYN and other prenatal care practitioners

- Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology.
- Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of

Primary Care Physician

A physician or non-physician (e.g., physician assistant, nurse practitioner) who offers primary care medical services. Includes:

- General of family practice physicians
- Geriatricians
- General internal medicine physicians
- General pediatricians
- Obstetricians/gynecologists (OB/GYN)