Patient-Centered Primary Care Home 2020 Recognition Criteria
Quick Reference Guide

Oregon Health Authority

Last Updated September 2020

This guide is intended to provide a brief overview of Oregon's Patient-Centered Primary Care Home (PCPCH) Program criteria for recognition that is effective January 1, 2021. The complete technical specifications for all measures are available at www.PrimaryCareHome.oregon.gov or by clicking here.

Please refer to the following definitions when using this document:

Unchanged: This measure was part of the 2017 criteria and language and/or point values have not changed
Revised: This measure was part of the 2017 criteria but proposed changes were made to language and/or point values
New: This measure was not part of the 2017 criteria and is a new measure to the model
(D): Quantitative data required at time of attestation

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

Tier Level	Point Range	Additional Required Criteria
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65 - 125 points	+ All must-pass standards
Tier 3	130 - 250 points	+ All must-pass standards
Tier 4	255 - 430 points	+ All must-pass standards
5 STAR (Tier 5)	255 - 430 points	+ All must-pass standards + Meet 13 out of 16 specified measures + All measures are verified with site visit

Important Note: Any practice applying for PCPCH recognition must review the technical specifications prior to submitting an application. The technical specifications describe each measure in more detail, including what documentation the practice must have to support their attestation. Practices must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted. The technical specifications for the 2020 criteria are available on the program website or by clicking here.

(D) = Quantitative data required at time of attestation

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*			
Standard 1.A) In-Person Access			
1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams.	**Revised**[1]	No	5
1.A.2 PCPCH regularly tracks timely access and communication to clinical staff and care teams, and has an improvement plan in place to improve their outcomes.	**Revised**[2]	No	10
Standard 1.B) After Hours Access			
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours. (D)	Unchanged	No	5
Standard 1.C) Telephone and Electronic Access			
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Unchanged	**Yes**	0
Standard 1.D) Same Day Access			
1.D.1 PCPCH provides same day appointments.	Unchanged	No	5
Standard 1.E) Electronic Access			
1.E.1 PCPCH provides patients with access to an electronic copy of their health information.	**Revised**[3]	No	5
Standard 1.F) Prescription Refills			
1.F.2 PCPCH tracks the time to completion for prescription refills.	Unchanged	No	10
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	Unchanged	No	15

[1] All measure language revised
[2] All measure language revised
[3] Some measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 1.G) Alternative Access *(Check all that apply)*			
1.G.1 PCPCH regularly communicates with patients through a patient portal.	**New**	No	5
1.G.2 PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.	**New**	No	10
CORE ATTRIBUTE 2: ACCOUNTABILITY - *"Take responsibility for making sure we receive the best possible health care."*			
Standard 2.A) Performance & Clinical Quality *(Check all that apply)* [4]			
2.A.0 PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures. (D)	**Revised**[5]	**Yes**	0
2.A.1 PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes three measures from the set of PCPCH Quality Measures.	**Revised**[6]	No	5
2.A.3 PCPCH tracks, reports to the OHA, and demonstrates a combination of improvement and meeting benchmarks on three of the PCPCH Quality measures. (D)	**Revised**[7]	No	15
Standard 2.B) Public Reporting			
2.B.1 PCPCH participates in a public reporting program for performance indicators and data collected for public reporting programs is shared with providers and staff within the PCPCH.	**Revised**[8]	No	5

[4] Now check all that apply
[5] Some measure language revised
[6] All measure language revised
[7] Some measure language revised
[8] Measure language added

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 2.C) Patient and Family Involvement in Quality Improvement			
2.C.1 PCPCH involves patients, families, and caregivers as advisors on at least one quality or safety initiative per year.	**Revised**[9]	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development and/or educational improvement activities.	**Revised**[10]	No	10
2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	**Revised**[11]	No	15
Standard 2.D) Quality Improvement			
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.	Unchanged	No	5
2.D.2 PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	Unchanged	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	Unchanged	No	15

[9] Some measure language revised
[10] Some measure language revised
[11] Some measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 2.E) Ambulatory Sensitive Utilization *(Check all that apply)*			
2.E.1 PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure.	**Revised** [12]	No	5
2.E.2 PCPCH identifies patients with unplanned or adverse utilization patterns for at least one selected utilization measure and contacts patients, families or caregivers for follow-up care if needed, within an appropriate period of time.	**Revised**[13]	No	10
2.E.3 PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure.	**Revised**[14]	No	15
Standard 2.F) PCPCH Staff Vitality			
2.F.1 PCPCH uses a structured process to identify opportunities to improve the vitality of its staff.	**New**	No	5
2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	**New**	No	10
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - ***"Provide or help us get the health care, information, and services we need."***			
Standard 3.A) Preventive Services			
3.A.1 PCPCH routinely offers or coordinates recommended preventive services appropriate for its population (i.e. age and gender) based on best available evidence, and identifies areas for improvement.	Unchanged	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services and has an improvement strategy in effect to address gaps in preventive service offerings as appropriate for the PCPCH patient population.	Unchanged	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	Unchanged	No	15

[12] All measure language revised
[13] All measure language revised
[14] Some measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 3.B) Medical Services			
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.	**Revised**[15]	**Yes**	0
Standard 3.C) Behavioral Health Services *(Check all that apply)*			
3.C.0 PCPCH has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes.	Unchanged	**Yes**	0
3.C.1 PCPCH collaborates and coordinates care or is co-located with specialty mental health, substance use disorders, and developmental providers. PCPCH also provides co-management based on its patient population needs.	**New**	No	5
3.C.2 PCPCH provides onsite pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	**Revised**[16]	No	10
3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	Unchanged	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention			
3.D.1 PCPCH has a routine assessment to identify health-related social needs in its patient population.	**Revised**[17]	No	5
3.D.2 PCPCH tracks referrals to community-based agencies for patients with health-related social needs.	**New**	No	10
3.D.3 PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs.	**New**	No	15

[15] Language added to measure
[16] All measure language revised
[17] All measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 3.E) Preventive Services Reminders			
3.E.2 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders.	Unchanged	No	10
3.E.3 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients, families, caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services.	Unchanged	No	15
Standard 3.F) Oral Health Services			
3.F.1 PCPCH utilizes a screening and/or assessment strategy for oral health needs.	**New**	No	5
3.F.2 PCPCH utilizes a screening and or/assessment strategy for oral health needs and provides age-appropriate interventions.	**New**	No	10
3.F.3 PCPCH provides oral health services by dental providers.	**New**	No	15
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*			
Standard 4.A) Personal Clinician Assigned			
4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team. (D)	Unchanged	**Yes**	0
4.A.3 PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team. (D)	Unchanged	No	15
Standard 4.B) Personal Clinician Continuity			
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Unchanged	**Yes**	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team.	Unchanged	No	10
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.	Unchanged	No	15

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Standard 4.C) Organization of Clinical Information			
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the Centers for Medicare and Medicaid Services and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.	**Revised**[18]	**Yes**	0
Standard 4.D) Clinical Information Exchange			
4.D.2 PCPCH exchanges clinical information electronically to another provider or setting of care.	**New**	No	10
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	Unchanged	No	15
Standard 4.E) Specialized Care Setting Transitions			
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Unchanged	**Yes**	0
Standard 4.F) Planning for Continuity			
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	Unchanged	No	5
Standard 4.G) Medication Reconciliation and Management			
4.G.2 PCPCH has a process for medication reconciliation for patients with complex or high-risk medication concerns.	**Revised**[19]	No	10
4.G.3 PCPCH provides Medication Management for patients with complex or high-risk medication concerns. (D)	**Revised**[20]	No	15

[18] All measure language revised
[19] Some measure language revised
[20] Some measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*			
Standard 5.A) Population Data Management *(Check all that apply)*			
5.A.1 PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its entire patient population, including the identification of sub-populations.	**Revised**[21]	No	5
5.A.2 PCPCH demonstrates the ability to stratify its entire patient population according to health risk such as special health care needs or health behavior.	**Revised**[22]	No	10
Standard 5.C) Complex Care Coordination *(Check all that apply)*			
5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care.	**Revised**[23]	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs.	**Revised**[24]	No	10
5.C.3 PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns.	**Revised**[25]	No	15
Standard 5.D) Test & Result Tracking			
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely, confidential notification and explanation of results to patients, family, or caregivers as well as to ordering clinicians.	**Revised**[26]	No	5

[21] Measure language added
[22] Measure language added
[23] Measure language added
[24] Measure language added
[25] Some measure language revised
[26] Measure language added

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 5.E) Referral & Specialty Care Coordination *(Check all that apply)*			
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians.	Unchanged	No	5
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (e.g. hospital, SNF, long term care facility).	Unchanged	No	10
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social service, foster care (either adult or child), public health, traditional health workers, school-based health center, behavioral health providers and organizations, and pharmacy services.	**Revised**[27]	No	15
Standard 5.F) End of Life Planning			
5.F.0 PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	Unchanged	**Yes**	0
5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries unless patients opt out.	Unchanged	No	5
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - *"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."*			
Standard 6.A) Meeting Language & Cultural Needs[28]			
6.A.0 PCPCH offers time-of-service translation to communicate with patients, families, or caregivers in their language of choice.	**Revised**[29]	**Yes**	0
6.A.1 PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic. (D)	**Revised**[30]	No	5

[27] Some measure language revised
[28] Previously called "Language/Cultural Interpretation"
[29] Some measure language revised
[30] Some measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 6.B) Education & Self-Management Support			
6.B.1 PCPCH provides patient-specific education resources to their patient population.	**Revised**[31]	No	5
6.B.2 PCPCH provides patient-specific education resources and offers self-management support resources to their patient population.	**Revised**[32]	No	10
6.B.3 PCPCH provides patient-specific education resources, offers self-management support resources to their patient population, and tracks utilization of multiple self-management groups.	**Revised**[33]	No	15
Standard 6.C) Experience of Care			
6.C.0 PCPCH surveys a sample of its population on their experience of care. The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. (D)	**Revised**[34]	**Yes**	0
6.C.1 PCPCH surveys a sample of its population on their experience of care. The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. PCPCH also has a survey planning strategy in place and shares data with clinic staff.	**New**	No	5
6.C.2 PCPCH surveys a sample of its population on their experience of care using of one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).	**Revised**[35]	No	10
6.C.3 PCPCH surveys a sample of its population on their experience of care using of one of the CAHPS survey tools, meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).	**Revised**[36]	No	15

[31] Some measure language revised
[32] All measure language revised
[33] All measure language revised
[34] Measure language condensed
[35] Some measure language revised
[36] Some measure language revised

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 6.D) Communication of Rights, Roles, and Responsibilities			
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.	**Revised**[37]	No	5

[37] Language added to measure