2014 PCPCH Standards - NCQA PCMH 2011 and 2014 Standards - Crosswalk

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
PCPCH Core Attribute 1: Access to Care Standard 1.A: In-Person Access 1.A.1 - PCPCH surveys a sample of its population on satisfaction with in-person access to care. 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. 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.	**PCMH 1: Enhance Access and Continuity** Element 1A: Access During Office Hours **Must-Pass – Critical Factor = 1** The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: 1. Providing same-day appointments 2. Providing timely clinical advice by telephone during office hours 3. Providing timely clinical advice by secure electronic messages during office hours 4. Documenting clinical advice in the medical record.	**PCMH 1: Patient-Centered Access** Element 1A: Patient-Centered Appointment Access **Must-Pass - Critical Factor = 1** The practice has a written process and defined standards for providing access to appointments and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care. 2. Providing routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no show rates 6. Acting on identified opportunities to improve access	For PCMH providing same day appointment for routine and urgent care is a must pass factor. It is not a must-pass standard for PCPCH although 97% of clinics attest to doing this.
PCPCH Core Attribute 1: Access to Care 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.	**PCMH 1: Enhance Access and Continuity** Element B: After Hours Access The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: 1. Providing access to routine and urgent-care appointments outside regular business hours 2. Providing continuity of medical record information for care and advice when the office is not open 3. Providing timely clinical advice by telephone when the office is not open 4. Providing timely clinical advice using a secure, interactive electronic system when the office is not open 5. Documenting after-hours clinical advice in patient records.	**PCMH 1: Patient-Centered Access** Element 1B: 24/7 Access to Clinical Advice The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times and regularly assesses its performance on: 1. . Providing continuity of medical record information for care and advice when the office is closed 2. Providing timely clinical advice by telephone 3. Providing timely clinical advice using a secure, interactive electronic system 4. Documenting clinical advice in patient records	
PCPCH Core Attribute 1: Access to Care Standard 1.C: Telephone & Electronic Access	Contained in 1A and 1B	Contained in 1A and 1B	24/7 access to clinical advice is not a must-pass standard for NCQA-PCMH but is for PCPCH.

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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.			
PCPCH Core Attribute 1: Access to Care Standard 1.D: Same Day Access 1.D.1 - PCPCH provides same day appointments.	**PCMH 1: Enhance Access and Continuity** Element 1A: Access During Office Hours **Must-Pass – Critical Factor = 1** The practice has a written process and defined standards, and demonstrates that it monitors performance against the standards for: 1. Providing same-day appointments 2. Providing timely clinical advice by telephone during office hours 3. Providing timely clinical advice by secure electronic messages during office hours 4. Documenting clinical advice in the medical record.	**PCMH 1: Patient-Centered Access** Element 1A: Patient-Centered Appointment Access **Must-Pass - Critical Factor = 1** The practice has a written process and defined standards for providing access to appointments and regularly assesses its performance on: 1. Providing same-day appointments for routine and urgent care. 2. Providing routine and urgent-care appointments outside regular business hours 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no show rates 6. Acting on identified opportunities to improve access	For NCQA-PCMH, same day appointments for routine care are a must-pass in 2011 PCMH. Same day appointments for both routine and urgent care are a must-pass in 2014 PCMH. Not a must-pass in PCPCH.
PCPCH Core Attribute 1: Access to Care Standard 1.E Electronic Access 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.	**PCMH 1: Enhance Access and Continuity** Element 1C: Electronic Access The practice provides the following information and services to patients and families through a secure electronic system. 1. More than 50 percent of patients who request an electronic copy of their health information (e.g., problem list, diagnoses, diagnostic test results, medication lists, allergies) receive it within three business days 2. At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists, and allergies) within four business days of when the information is available to the practice 3. Clinical summaries are provided to patients for more than 50 percent of office visits within three business days	**PCMH 1: Patient-Centered Access** Element 1C: Electronic Access The following information and services are provided to patients/families/caregivers as specified through a secure electronic system. 1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+ 2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+ 3. Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits+ 4. A secure message was sent by more than 5 percent of patients+ 5. Patients have two-way communication with the practice	

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	4. Two-way communication between patients/families and the practice 5. Request for appointments or prescription refills 6. Request for referrals or test results	6. Patients can request appointments, prescription refills, referrals and test results + = Stage 2 Core Meaningful Use Requirement	
PCPCH Core Attribute 1: Access to Care Standard 1.F: Prescription Refills 1.F.1 - PCPCH tracks the time to completion for prescription refills.	Not addressed	Not addressed	There is a PCMH standard (1.C.5) around patients being able to electronically access request for appointment refills but not around the clinic tracking time to completion for refills.
PCPCH Core Attribute 2: Accountability Standard 2.A : Performance & Clinical Quality 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. 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.	**PCMH 6: Measure and Improve Performance** Element 6A: Measure Performance The practice measures or receives data on the following: 1. At least three preventive care measures 2. At least three chronic or acute care clinical measures 3. At least two utilization measures affecting health care costs 4. Performance data stratified for vulnerable populations (to assess disparities in care). Element C: Implement Continuous Quality Improvement **(Must-Pass)** The practice uses an ongoing quality improvement process to: 1. Set goals and act to improve performance on at least three measures from Element A 2. Set goals and act to improve performance on at least one measure from Element B 3. Set goals and address at least one identified disparity in care or service for vulnerable populations 4. Involve patients/families in quality improvement teams or on the practice's advisory council. Need at least 2 out of 4 factors to meet this must-pass Element D: Demonstrate Continuous Quality Improvement	**PCMH 6: Performance Measurement and Quality Improvement** Element 6A: Measure Clinical Quality Performance At least annually, the practice measures or receives data on: 1. At least two immunization measures 2. At least two other preventive care measures 3. At least three chronic or acute care clinical measures 4. Performance data stratified for vulnerable populations (to assess disparities in care). Element D: Implement Continuous Quality Improvement (**Must-pass**) The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least three clinical quality measures from Element A. 2. Act to improve at least three clinical quality measures from Element A. 3. Set goals and analyze at least one measure from Element B. 4. Act to improve at least one measure from Element B. 5. Set goals and analyze at least one patient experience measure from Element C. 6. Act to improve at least one patient experience measure from Element C. 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations. Need at least 5 out of 7 factors to meet this must-pass	Utilization measures affecting health care costs are included in PCMH standards but not PCPCH. PCMH standards give credit for stratifying performance data for vulnerable populations to assess disparities in care.

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	The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by: 1. Tracking results over time 2. Assessing the effect of its actions 3. Achieving improved performance on one measure 4. Achieving improved performance on a second measure	Element 6E: Demonstrate Continuous Quality Improvement The practice demonstrates continuous quality improvement by: 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 2. Achieving improved performance on at least two clinical quality measures 3. Achieving improved performance on one utilization or care coordination measure 4. Achieving improved performance on at least one patient experience measure	
PCPCH Core Attribute 2: Accountability Standard 2.B: Public Reporting 2.B.1 - PCPCH participates in a public reporting program for performance indicators. 2.B.2 - Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	**PCMH 6: Measure and Improve Performance** Element 6E: Report Performance The practice shares performance data from Element A and Element B: 1. Within the practice, results by individual clinician 2. Within the practice, results across the practice 3. Outside the practice to patients or publicly, results across the practice or by clinician Element 6F: Report Data Externally The practice electronically reports: 1. Ambulatory clinical quality measures to CMS+ 2. Ambulatory clinical quality measures to other external entities 3. Data to immunization registries or systems++ 4. Syndromic surveillance data to public health agencies++	**PCMH 6: Performance Measurement and Quality Improvement** Element 6F: Report Performance The practice produces performance data reports using measures from Elements A, B and C and shares: 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice 3. Individual clinician or practice-level performance results publicly 4. Individual clinician or practice-level performance results with patients	
PCPCH Core Attribute 2: Accountability Standard 2.C: Patient and Family Involvement in Quality Improvement 2.C.1- PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year.	**PCMH 6: Measure and Improve Performance** Element C: Implement Continuous Quality Improvement **(Must-Pass)** The practice uses an ongoing quality improvement process to: 1. Set goals and act to improve performance on at least three measures from Element A	**PCMH 6: Performance Measurement and Quality Improvement** Element 6D: Implement Continuous Quality Improvement **(Must-Pass)** The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least three clinical quality measures from Element A	

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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. 2.C.3 - Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	2. Set goals and act to improve performance on at least one measure from Element B 3. Set goals and address at least one identified disparity in care or service for vulnerable populations 4. Involve patients/families in quality improvement teams or on the practice's advisory council. Need at least 2 out of 4 factors to meet this must-pass	2. Act to improve at least three clinical quality measures from Element A 3. Set goals and analyze at least one measure from Element B 4. Act to improve at least one measure from Element B 5. Set goals and analyze at least one patient experience measure from Element C 6. Act to improve at least one patient experience measure from Element C 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations Need at least 5 out of 7 factors to meet this must-pass **PCMH 2: Team-Based Care** Element 2D: The Practice Team **(Must-Pass – Critical Factor = 3)** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	

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PCPCH Core Attribute 2: Accountability 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. 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. 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.	**PCMH 6: Measure and Improve Performance** Element 6C: Implement Continuous Quality Improvement **(Must-pass)** The practice uses an ongoing quality improvement process to: 1. Set goals and act to improve on at least three measures from Element A 2. Set goals and act to improve quality on at least one measure from Element B 3. Set goals and address at least one identified disparity in care/service for vulnerable populations 4. Involve patients/families in quality improvement teams or on the practice's advisory council Need at least 2 out of 4 factors to meet this must-pass Element 6D: Demonstrate Continuous Quality Improvement The practice demonstrates ongoing monitoring the effectiveness of its improvement process by: 1. Tracking results over time 2. Assessing the effect of its actions 3. Achieving improved performance on one measure 4. Achieving improved performance on a second measure	**PCMH 6: Performance Measurement and Quality Improvement** Element 6D: Implement Continuous Quality Improvement **(Must-pass)** The practice uses an ongoing quality improvement process to: 1. Set goals and analyze at least three clinical quality measures from Element A 2. Act to improve at least three clinical quality measures from Element A 3. Set goals and analyze at least one measure from Element B 4. Act to improve at least one measure from Element B 5. Set goals and analyze at least one patient experience measure from Element C 6. Act to improve at least one patient experience measure from Element C 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations Need at least 5 out of 7 factors to meet this must-pass Element 6E: Demonstrate Continuous Quality Improvement The practice demonstrates continuous quality improvement by: 1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D 2. Achieving improved performance on at least two clinical quality measures 3. Achieving improved performance on one utilization or care coordination measure 4. Achieving improved performance on at least one patient experience measure	
PCPCH Core Attribute 2: Accountability Standard 2.E: Ambulatory Sensitive Utilization	**PCMH 6: Measure and Improve Performance** Element 6A: Measure Performance The practice measures or receives data on the following:	**PCMH 6: Performance Measurement and Quality Improvement** Element 6A: Measure Clinical Quality Performance	

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2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population. 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. 2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	1. At least three preventive care measures 2. At least three chronic or acute care clinical measures 3. At least two utilization measures affecting health care costs 4. Performance data stratified for vulnerable populations (to assess disparities in care)	At least annually, the practice measures or receives data on: 1. At least two immunization measures 2. At least two other preventive care measures 3. At least three chronic or acute care clinical measures 4. Performance data stratified for vulnerable populations (to assess disparities in care).	
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.A : Preventive Services 3.A.1 - PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence. 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. 3.A.3 - PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services	Not addressed **PCMH 2: Identify and Manage Patient Populations** Element 2D: Use Data for Population Management **(Must-Pass)** The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients and to proactively remind patients/families and clinicians of services needed for: 1. At least three different preventive care services++ 2. At least three different chronic or acute care services++ 3. Patients not recently seen by the practice 4. Specific medications Need to do at least 2 out of 4 factors to pass this must-pass.	Not addressed **PCMH 3: Population Health Management** Element 3D: Use Data for Population Management **(Must-Pass)** At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including: 1. At least two different preventive care services+ 2. At least two different immunizations+ 3. At least three different chronic or acute care services+ 4. Patients not recently seen by the practice 5. Medication monitoring or alert + Stage 2 Core Meaningful Use Requirement Need to do at least 2 out of 5 factors to pass this must-pass.	NCQA-PCMH model does not suggest specific preventative services that the clinic should provide.
PCPCH Core Attribute 3: Comprehensive Whole-Person Care 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	Not addressed	Not addressed	

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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)**			
PCPCH Core Attribute 3: Comprehensive Whole-Person Care 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. **(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. 3.C.3 - PCPCH is co-located either actually or virtually with specialty mental health, substance abuse, or developmental providers.	**PCMH 2: Identify and Manage Patient Populations** Element 2C: Comprehensive Health Assessment To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: 1. Documentation of age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Patient and family mental health/substance abuse 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) 9. Depression screening for adults and adolescents using a standardized tool **PCMH 4: Provide Self-Care Support and Community Resources** Element 4B: Provide Referrals to Community Resources The practice supports patients/families that need access to community resources: 1. Maintains a current resource list on five topics or key community service of importance to practice population 2. Tracks referrals provided to patients/families 3. Arranges or provides treatment for mental health and substance abuse disorders 4. Offers opportunities for health educational programs (such as group classes and peer support)	**PCMH 3: Population Health Management** Element 3C: Comprehensive Health Assessment To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes: 1. Age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices)- 6. Behaviors affecting health 7. Mental health/substance use history of patient and family 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) 9. Depression screening for adults and adolescents using a standardized tool 10. Assessment of health literacy **PCMH 5: Care Coordination and Care Transitions** Element 5B: Referral Tracking and Follow-Up **(Must-Pass – Critical Factor = 8)** The practice: 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers **4**. Integrates behavioral healthcare providers within the practice site	

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		5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan 7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+ 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports 9. Documents co-management arrangements in the patient's medical record 10. Asks patients/families about self-referrals and requesting reports from clinicians + Stage 2 Core Meaningful Use Requirement Need to meet at least 4 out of 10 factors including critical factor to meet this must-pass **PCMH 2: Team-Based Care** Element 2B: Medical Home Responsibilities The practice has a process for informing patients/ families about the role of the medical home and gives patients/families materials that contain the following information: 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice 4. The care team provides access to evidence-based care, patient/family education and self-management support **5. The scope of services available within the practice including how behavioral health needs are addressed** 6. The practice provides equal access to all of their patients	

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		regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage 8. Instructions on transferring records to the practice, including a point of contact at the practice **PCMH 4: Care Management and Support** Element 4A: Identify Patients for Care Management The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria	
PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.D : Comprehensive Health Assessment & Intervention 3.D.1 - PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	**PCMH 2: Identify and Manage Patient Populations** Element 2C: Comprehensive Health Assessment To understand the health risks and information needs of patients/families, the practice conducts and documents a comprehensive health assessment that includes: 1. Documentation of age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Patient and family mental health/substance abuse 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) 9. Depression screening for adults and adolescents using a standardized tool	**PCMH 3: Population Health Management** Element 3C: Comprehensive Health Assessment To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes: 1. Age- and gender appropriate immunizations and screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices)- 6. Behaviors affecting health 7. Mental health/substance use history of patient and family 8. Developmental screening using a standardized tool (NA for practices with no pediatric patients) 9. Depression screening for adults and adolescents using a standardized tool 10. Assessment of health literacy	

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PCPCH Core Attribute 3: Comprehensive Whole-Person Care Standard 3.E - Preventive Service Reminders 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. 3.E.2 - PCPCH tracks the number of unique patients who were sent appropriate reminders. 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.	**PCMH 2: Identify and Manage Patient Populations** Element 2D: Use Data for Population Management **(Must-Pass)** The practice uses patient information, clinical data and evidence-based guidelines to generate lists of patients *and* to proactively remind patients/families and clinicians of services needed for: 1. At least three different preventive care services++ 2. At least three different chronic or acute care services++ 3. Patients not recently seen by the practice 4. Specific medications Need to do at least 2 out of 4 factors to pass this must-pass.	**PCMH 3: Population Health Management** Element 3D: Use Data for Population Management **(Must-Pass)** At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including: 1. At least two different preventive care services+ 2. At least two different immunizations+ 3. At least three different chronic or acute care services+ 4. Patients not recently seen by the practice 5. Medication monitoring or alert + Stage 2 Core Meaningful Use Requirement Need to do at least 2 out of 5 factors to pass this must-pass.	
PCPCH Core Attribute 4: Continuity Standard 4.A : Personal Clinician Assigned 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.	**PCMH 1: Enhance Access and Continuity** Element 1D: Continuity The practice provides continuity of care for patients/families by: 1. Expecting patients/families to select a personal clinician 2. Documenting the patient's/family's choice of clinician 3. Monitoring the percentage of patient visits with selected clinician or team	**PCMH 2: Team-Based Care** Element 2A: Continuity The practice provides continuity of care for patients/families by: 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected clinician or team 3. Having a process to orient new patients to the practice 4. Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care	PCMH Standards do not require reporting of percentage of patients assigned to personal clinician while PCPCH requires this.
PCPCH Core Attribute 4: Continuity Standard 4.B: Personal Clinician Continuity 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	**PCMH 1: Enhance Access and Continuity** Element 1D: Continuity The practice provides continuity of care for patients/families by: 1. Expecting patients/families to select a personal clinician 2. Documenting the patient's/family's choice of clinician	**PCMH 2: Team-Based Care** Element 2A: Continuity The practice provides continuity of care for patients/families by: 1. Assisting patients/families to select a personal clinician and documenting the selection in practice records 2. Monitoring the percentage of patient visits with selected	PCMH Standards do not require reporting percent of patients visits with assigned clinician or team while PCPCH requires this.

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visits with assigned clinician or team. 4.B.3 - PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.	3. Monitoring the percentage of patient visits with selected clinician or team	clinician or team 3. Having a process to orient new patients to the practice 4. Collaborating with the patient/family to develop/implement a written care plan for patients transitioning from pediatric care to adult care	
PCPCH Core Attribute 4: Continuity 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. **(Must Pass)**	**PCMH 2: Identify and Manage Patient Populations** Element 2A: Patient Information The practice uses an electronic system that records the following as structured (searchable) data for >50% of the patients. 1. Date of birth+ 2. Gender+ 3. Race+ 4. Ethnicity+ 5. Preferred language+ 6. Telephone numbers 7. E-mail address 8. Dates of previous clinical visits 9. Legal guardian/health care proxy 10. Primary caregiver 11. Presence of advance directives (NA for pediatric practices) 12. Health insurance information	**PCMH 3: Population Health Management** Element 3A: Patient Information The practice uses an electronic system to records patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients: 1. Date of birth+ 2. Sex+ 3. Race+ 4. Ethnicity+ 5. Preferred language+ 6. Telephone numbers 7. E-mail address 8. Occupation (NA for pediatric practices) 9. Dates of previous clinical visits 10. Legal guardian/health care proxy 11. Primary caregiver 12. Presence of advance directives (NA for pediatric practices) 13. Health insurance information 14. Name and contact information of other health care professionals involved in patient's care +Stage 2 Core Meaningful Use Requirement	
PCPCH Core Attribute 4: Continuity Standard 4.D: Clinical Information Exchange 4.D.3 - PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	**PCMH 5: Track and Coordinate Care** Element 5C: Coordinate With Facilities and Care Transitions On its own or in conjunction with an external organization, the practice systematically: 1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit	**PCMH 5: Care Coordination and Care Transitions** Element 5C: Coordinate Care Transitions The practice: 1. Proactively identifies patients with unplanned hospital admissions and emergency department visits 2. Shares clinical information with admitting hospitals and emergency departments 3. Consistently obtains patient discharge summaries from the	

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	2. Demonstrates its process for sharing clinical information with admitting hospitals or emergency departments 3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities . 4. Demonstrates its process for contacting patients/ families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization 6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult-only and family practices) 7. Demonstrates the ability for electronic exchange of key clinical information with facilities 8. Provides an electronic summary-of-care record to another care facility for >50% of transitions of care++	hospital and other facilities 4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Exchanges patient information with the hospital during a patient's hospitalization 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+ +Stage 2 Core Meaningful Use Requirement	
PCPCH Core Attribute 4: Continuity 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. **(Must-pass)**	Not addressed	Not addressed	
PCPCH Core Attribute 4: Continuity 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	Not addressed	Not addressed	
PCPCH Core Attribute 4: Continuity Standard 4.G: Medication Reconciliation	**PCMH 3: Plan and Manage Care** Element 3D: Medication Management	**PCMH 4: Care Management and Support** Element 4C: Medication Management	

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
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. 4.G.2 - PCPCH tracks the percentage of patients whose medication regimen is reconciled. 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.	The practice manages medications in the following ways. 1. Reviews and reconciles medications with patients/ families for >50% of care transitions++ 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions 3. Provides information about new prescriptions to more than 80 percent of patients/families 4. Assesses patient/family understanding of medications for >50% of patients with date of assessment	The practice has a process for managing medications, and systematically implements the process in the following ways: 1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions+ 2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions 3. Provides information about new prescriptions to more than 80 percent of patients/families/ caregivers.	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.A : Population Data Management 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.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.	**PCMH 3: Plan and Manage Care** Element 3B: Identify High- Risk Patients To identify high-risk or complex patients the practice: 1. Establishes criteria and a systematic process to identify high-risk or complex patients 2. Determines the percentage of high-risk or complex patients in its population	**PCMH 4: Care Management and Support** Element 4A: Identify Patients for Care Management The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.B : Electronic Health Record 5.B.3 - PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be "meaningful users" of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	**PCMH 2: Identify and Manage Patient Populations** Element 2A: Patient Information The practice uses an electronic system that records the following as structured (searchable) data for >50% of the patients. 1. Date of birth+ 2. Gender+ 3. Race+ 4. Ethnicity+ 5. Preferred language+ 6. Telephone numbers 7. E-mail address	**PCMH 3: Population Health Management** Element 3A: Patient Information The practice uses an electronic system to records patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients: 1. Date of birth+ 2. Sex+ 3. Race+ 4. Ethnicity+ 5. Preferred language+ 6. Telephone numbers	

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
	8. Dates of previous clinical visits 9. Legal guardian/health care proxy 10. Primary caregiver 11. Presence of advance directives (NA for pediatric practices) 12. Health insurance information	7. E-mail address 8. Occupation (NA for pediatric practices) 9. Dates of previous clinical visits 10. Legal guardian/health care proxy 11. Primary caregiver 12. Presence of advance directives (NA for pediatric practices) 13. Health insurance information 14. Name and contact information of other health care professionals involved in patient's care +Stage 2 Core Meaningful Use Requirement	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.C : Complex Care Coordination 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.C.2 - PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. 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.	**PCMH 3: Plan and Manage Care** Element 3B: Identify High- Risk Patients To identify high-risk or complex patients the practice: 1. Establishes criteria and a systematic process to identify high-risk or complex patients 2. Determines the percentage of high-risk or complex patients in its population Element 3C: Care Management **(Must-Pass)** The care team performs the following for at least 75 percent of the patients for the patients identified in Elements A and B: 1. Conducts pre-visit preparations 2. Collaborates with the patient/family to develop an individualized care plan, including treatment goals that are reviewed and updated at each relevant visit 3. Gives the patient/family a written plan of care 4. Assesses and addresses barriers when patient has not met treatment goals 5. Provides patient/family a clinical summary at each relevant visit 6. Identifies patients/families who might benefit from additional care management support 7. Follows up with patients/families who have not kept important appointments Need to meet at least 3 out of 7 factors to meet this must-pass.	**PCMH 4: Care Management and Support** Element 4A: Identify Patients for Care Management The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: 1. Behavioral health conditions 2. High cost/high utilization 3. Poorly controlled or complex conditions 4. Social determinants of health 5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver 6. The practice monitors the percentage of the total patient population identified through its process and criteria Element 4B: Care Planning and Self-Care Support **(Must-Pass)** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A: 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals 4. Includes a self-management plan 5. Is provided in writing to the patient/family/ caregiver Need to meet at least 3 out of 5 factors to meet this must-	In the PCMH model, care management and care plans are must pass elements. They are not a must-pass in the PCPCH model.

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
		pass.	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.D : Test & Result Tracking 5.D.1 - PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.	**PCMH 5: Track and Coordinate Care** Element 5A: Test Tracking and Follow-Up The practice has a documented process for and demonstrates that it: 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows-up with inpatient facility on newborn hearing and newborn blood-spot screening (NA for adults) 7. Electronically communicates with labs to order tests and retrieve results	**PCMH 5: Care Coordination and Care Transitions** Element 5A: Test Tracking and Follow-Up The practice has a documented process for and demonstrates that it: 1. Tracks lab tests until results are available, flagging and following up on overdue results 2. Tracks imaging tests until results are available, flagging and following up on overdue results 3. Flags abnormal lab results, bringing them to the attention of the clinician 4. Flags abnormal imaging results, bringing them to the attention of the clinician 5. Notifies patients/families of normal and abnormal lab and imaging test results 6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults) 7. More than 30 percent of laboratory orders are electronically recorded in the patient record+	
PCPCH Core Attribute 5: Coordination and Integration Standard 5.E: Referral & Specialty Care Coordination 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.E.2 - PCPCH demonstrates active involvement and coordination of care when its patients receive care in Specialized settings (hospital, SNF, long term care facility). 5.E.3 - 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.	**PCMH 5: Track and Coordinate Care** Element 5B: Referral Tracking and Follow-Up **(Must-Pass)** The practice coordinates referrals by: 1. Giving the consultant or specialist the clinical reason for the referral and pertinent clinical information 2. Tracking the status of the referrals, including required timing for receiving a specialist's report 3. Following up to obtain specialist's report 4. Establishing and documenting agreements with specialists in the medical record if co-management is needed 5. Asking patients/families about self-referrals and requesting reports from clinicians 6. Demonstrating capacity for electronic exchange of key clinical information (e.g., problem list, medication list, allergies, diagnostic test results) between clinicians+ 7. Providing an electronic summary of care record to	**PCMH 5: Care Coordination and Care Transitions** Element 5B: Referral Tracking and Follow-Up **(Must Pass – Critical Factor = 8)** The practice: 1. Considers available performance information on consultants/specialists when making referral recommendations 2. Maintains formal and informal agreements with a subset of specialists based on established criteria 3. Maintains agreements with behavioral healthcare providers 4. Integrates behavioral healthcare providers within the practice site 5. Gives the consultant or specialist the clinical question, the required timing and the type of referral 6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan	

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
	another provider for >50% of referrals++ Need to meet at least 3 out of 7 factors to meet this must-pass Element 5C: Coordinate With Facilities and Care Transitions On its own or in conjunction with an external organization, the practice systematically: 1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit 2. Demonstrates its process for sharing clinical information with admitting hospitals or emergency departments 3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities 4. Demonstrates its process for contacting patients/ families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Demonstrates its process for exchanging patient information with the hospital during a patient's hospitalization 6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult-only and family practices) 7. Demonstrates the ability for electronic exchange of key clinical information with facilities 8. Provides an electronic summary-of-care record to another care facility for >50% of transitions of care++	7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+ 8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports 9. Documents co-management arrangements in the patient's medical record 10. Asks patients/families about self-referrals and requesting reports from clinicians + Stage 2 Core Meaningful Use Requirement Need to meet at least 4 out of 10 factors including critical factor Element 5C: Coordinate Care Transitions The practice: 1. Proactively identifies patients with unplanned hospital admissions and emergency department visits 2. Shares clinical information with admitting hospitals and emergency departments 3. Consistently obtains patient discharge summaries from the hospital and other facilities 4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit 5. Exchanges patient information with the hospital during a patient's hospitalization 6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners 7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+ +Stage 2 Core Meaningful Use Requirement	
PCPCH Core Attribute 5: Coordination and Integration	Not addressed	Not addressed	End of Life Planning is not addressed in the NCQA-PCMH model

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
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 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).			
PCPCH Core Attribute 6: Person and Family Centered Care 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. (**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.	**PCMH 1: Enhance Access and Continuity** Element 1F: Culturally and Linguistically Appropriate Services (CLAS) The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/ families. 1. Assessing the racial and ethnic diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population	**PCMH 2: Team-Based Care** Element 2C: Culturally and Linguistically Appropriate Services The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: 1. Assessing the diversity of its population 2. Assessing the language needs of its population 3. Providing interpretation or bilingual services to meet the language needs of its population 4. Providing printed materials in the languages of its population	Not required in the NCQA-PCMH model
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.B - Education & Self-Management Support 6.B.1 - PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate.	**PCMH 4: Provide Self-Care Support and Community Resources** Element 4A: Support Self-Care Process **(Must-Pass – Critical Factor = 3)** The practice conducts activities to support patients/ families in self-management: 1. Provides educational resources or refers at least 50 percent of patients/families to educational resources to	**PCMH 4: Provide Self-Care Support and Community Resources** Element 4E: Support Self-Care and Shared Decision Making The practice has, and demonstrates use of, materials to support patients and families/ caregivers in self-management and shared decision making. The practice: 1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+	In the NCQA-PCMH it is required that clinic develops and documents self-management plans and goals in collaboration with at least 50% or patients/families. This is not required in the PCPCH model.

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
6.B.2 - More than 10% of unique patients are provided patient-specific education resources. 6.B.3 - More than 10% of unique patients are provided patient-specific education resources and self-management services.	assist in self-management 2. Uses an EHR to identify patient-specific education resources and provide to more than 10 percent of patients, if appropriate++ 3. Develops and documents self-management plans and goals in collaboration with at least 50 percent of patients/families 4. Documents self-management abilities for at least 50 percent of patients/families 5. Provides self-management tools to record self-care results for at least 50 percent of patients/families 6. Counsels at least 50 percent of patients/families to adopt healthy behaviors Need to meet at least 3 out of 6 factors including critical factor)	2. Provides educational materials and resources to patients 3. Provides self-management tools to record self-care results 4. Adopts shared decision making aids 5. Offers or refers patients to structured health education programs such as group classes and peer support 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates 7. Assesses usefulness of identified community resources. + Stage 2 Core Meaningful Use Requirement	
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.C: Experience of Care 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. 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. 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	**PCMH 6: Measure and Improve Performance** Element 6B: Measure Patient/Family Experience The practice obtains feedback from patients/ families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: · Access · Communication · Coordination · Whole person care/self-management support 2. The practice uses the Patient-Centered Medical Home (PCMH) version of the CAHPS Clinician & Group Survey Tool 3. The practice obtains feedback on experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means	**PCMH 6: Performance Measurement and Quality Improvement** Element 6C: Measure Patient/Family Experience At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care. 1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: · Access · Communication · Coordination · Whole person care/self-management support 2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool 3. The practice obtains feedback on experiences of vulnerable patient groups 4. The practice obtains feedback from patients/families through qualitative means	

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
staff helpfulness.			
PCPCH Core Attribute 6: Person and Family Centered Care Standard 6.D: Communication of Rights, Roles, and Responsibilities 6.D.1 - PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	**PCMH 1: Enhance Access and Continuity** Element 1E: Medical Home Responsibilities The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following. 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside of the practice 4. The care team provides the patient/family with access to evidence-based care and self-management support	**PCMH 2: Team-Based Care** Element 2B: Medical Home Responsibilities The practice has a process for informing patients/ families about the role of the medical home and gives patients/families materials that contain the following information: 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice 4. The care team provides access to evidence-based care, patient/family education and self-management support 5. The scope of services available within the practice including how behavioral health needs are addressed 6. The practice provides equal access to all of their patients regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage 8. Instructions on transferring records to the practice, including a point of contact at the practice	
NOT IN PCPCH MODEL	**PCMH 1: Enhance Access and Continuity** Element 1E: Medical Home Responsibilities The practice has a process and materials that it provides to patients/families on the role of the medical home, which include the following. 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions on obtaining care and clinical advice during office hours and when the office is closed 3. The practice functions most effectively as a medical	**PCMH 2: Team-Based Care** Element 2B: Medical Home Responsibilities The practice has a process for informing patients/ families about the role of the medical home and gives patients/families materials that contain the following information: 1. The practice is responsible for coordinating patient care across multiple settings 2. Instructions for obtaining care and clinical advice during office hours and when the office is closed	

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
	home if patients provide a complete medical history and information about care obtained outside of the practice 4. The care team provides the patient/family with access to evidence-based care and self-management support	3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice 4. The care team provides access to evidence-based care, patient/family education and self-management support 5. The scope of services available within the practice including how behavioral health needs are addressed 6. The practice provides equal access to all of their patients regardless of source of payment 7. The practice gives uninsured patients information about obtaining coverage 8. Instructions on transferring records to the practice, including a point of contact at the practice	
NOT IN PCPCH MODEL	**PCMH 1: Enhance Access and Continuity** Element 1G: The Practice Team The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Having regular team meetings or a structured communication process 3. Using standing orders for services 4. Training and assigning care teams to coordinate care for individual patients 5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change 6. Training and assigning care teams for patient population management 7. Training and designating care team members in communication skills 8. Involving care team staff in the practice's performance evaluation and quality improvement activities	**PCMH 2: Team-Based Care** Element 2D: The Practice Team The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying practice organizational structure and staff leading and sustaining team based care 3. Having regular patient care team meetings or a structured communication process focused on individual patient care 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding regular team meetings addressing practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	In the 2014 PCMH it is a must-pass factor to have regular patient care team meetings or a structured communication process focused on individual patient care. It is not a must-pass in the PCPCH model.

Oregon PCPCH 2014 Standards	NCQA PCMH 2011	NCQA PCMH 2014	Key Differences
NOT IN PCPCH MODEL	**PCMH 6: Measure and Improve Performance** Element 6E: Report Performance The practice shares performance data from Element A and Element B: 1. Within the practice, results by individual clinician 2. Within the practice, results across the practice 3. Outside the practice to patients or publicly, results across the practice or by clinician	**PCMH 6: Performance Measurement and Quality Improvement** Element 6F: Report Performance The practice produces performance data reports using measures from Elements A, B and C and shares: 1. Individual clinician performance results with the practice 2. Practice-level performance results with the practice 3. Individual clinician or practice-level performance results publicly 4. Individual clinician or practice-level performance results with patients	

Resource links:

PCPCH Quick Reference Guide: http://www.oregon.gov/oha/pcpch/Documents/2014%20PCPCH%20Criteria%20Quick%20Reference.pdf

Crosswalk of NCQA PCMH 2011 with 2014: http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCMH2011PCMH2014Crosswalk.aspx