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**Office for  
Oregon Health Policy and Research**



# **Standards and Measures for Patient Centered Primary Care Homes**

**Final Report of the  
Patient Centered Primary Care Home (PCPCH)  
Standards Advisory Committee**

**February 2010**

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## EXECUTIVE SUMMARY

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

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

To assist OHPR in developing strategies to identify and measure patient centered primary care homes, the OHA Director appointed a 15 member Patient Centered Primary Care Home Standards Advisory Committee (the committee) made up of a diverse group of Oregon stakeholders including patients, clinicians, health plans and payers. Over the course of seven meetings between October 2009 and January 2010, the committee developed six core attributes (Access to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration and Person and Family Centered Care) and a number of standards that describe the care delivered by patient centered primary care homes. The committee articulated its core attributes and standards in patient-centered language in order to help communicate the benefits of this new model of care to the general public.

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

The committee believes that Oregonians will realize significant benefits if primary care clinics across Oregon adopt the patient centered primary care home model of care. However, missteps in application of the proposed measures could worsen the current financing and workforce challenges facing primary care, and ultimately reduce the ability of Oregonians to access high quality health care. The committee developed a number of guiding principles to assist policymakers in implementing the proposed measures in a way most likely to achieve the triple aim goals. These guiding principles are divided into five categories: strategies for payment reform, incentives for delivery system change, strategies for measurement, encouraging continuous improvement and aligning incentives across the health care system.

## INTRODUCTION

The Oregon Health Fund Board (HFB) was formed in 2007 at the direction of the Oregon Legislature to develop a comprehensive plan for reforming Oregon’s health care system. The Health Fund Board identified stimulating innovation and improvement within the health care delivery system as a key building block to achieving the “triple aim” of health care reform: a healthy population, extraordinary patient care for everyone, and reasonable costs shared equitably.<sup>1,2</sup> The HFB identified the development of Patient-Centered Primary Care Homes<sup>3</sup> as a central strategy for improving the health care delivery system.

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

### A Healthy Population

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

### Extraordinary Patient Care

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

### Reasonable Costs

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

The conceptual work of the HFB on primary care homes was incorporated into two pieces of legislation enacted during the 2009 legislative session: HB 2009 created the Oregon Health Authority and established a Patient Centered Primary Care Home program within the Office for Oregon Health Policy and Research (OHPR), and HB 3418 required the Oregon Health Authority (OHA) to study the feasibility of alternative payment models for primary care homes within the Medicaid program. This report contains the findings of an advisory committee convened to assist OHPR in the first phase of its Patient Centered Primary Care Home Program: developing standards and measures for Patient Centered Primary Care Homes.

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<sup>1</sup> Oregon Health Fund Board. *Aim High: Building a Healthy Oregon. Final Report.* November 2008.

<sup>2</sup> Oregon Health Fund Board. *Delivery Systems Committee Recommendations. Report to the Oregon Health Fund Board.* May 2008.

<sup>3</sup> Multiple terms have been used to identify this new model of primary care. The terms patient-centered primary care home and primary care home are contained in Oregon law and are used in this report. The Health Fund Board described integrated health homes and nationally, similar concepts have been known by the names patient-centered medical home, advanced primary care or simply medical home.

## WORK OF THE PATIENT-CENTERED PRIMARY CARE HOME STANDARDS ADVISORY COMMITTEE

### Key Tasks and Work Products

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

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

The PCPCH Standards Advisory Committee (the committee) was appointed by the OHA Director in October 2009 to develop policy recommendations around the first three objectives above. The committee held seven public meetings between November 2009 and January 2010. A complete committee roster can be found in Appendix A and a summary and audio recording of each meeting is available on the OHPR website ([www.oregon.gov/OHPPR](http://www.oregon.gov/OHPPR)). In addition to the committee's work, OHPR staff reviewed prior work on the primary care home<sup>4</sup> including the work of the Oregon Health Fund Board and its Delivery System Subcommittee, met with numerous experts and stakeholders across Oregon and conducted extensive background research on primary care home policy nationally and in other states to develop the contents of this report.

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

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

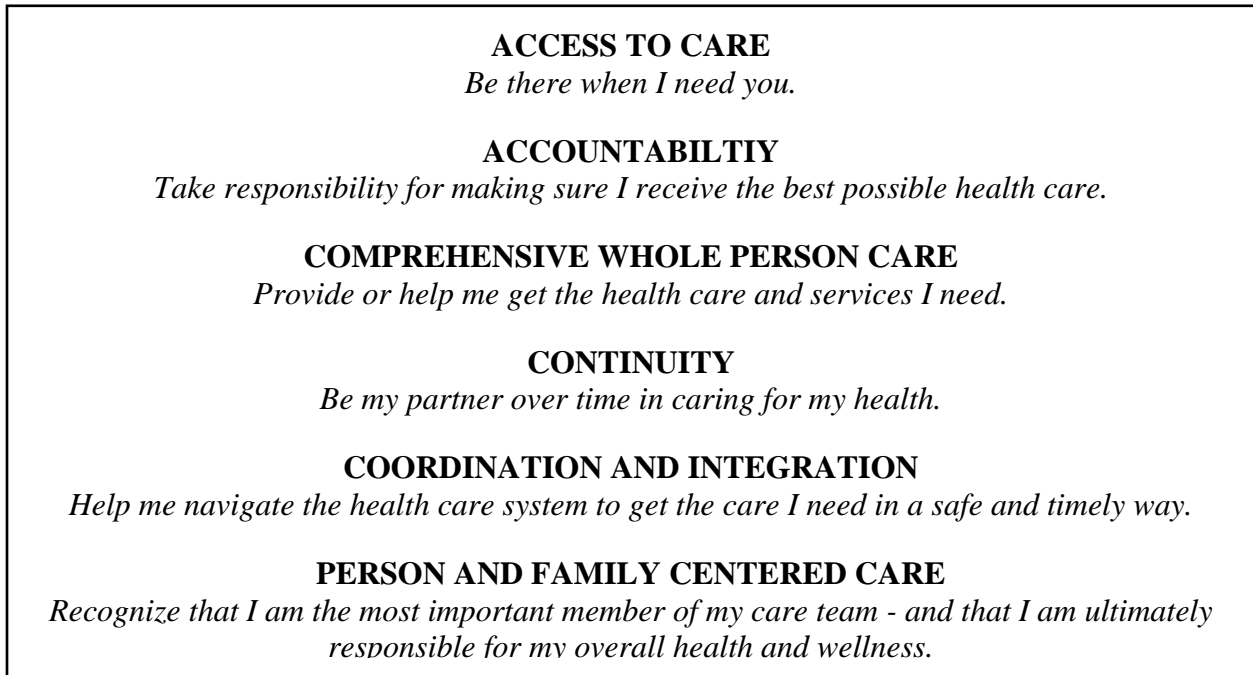
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<sup>4</sup> OHPR. *The Medical Home Model of Primary Care: Implications for the Health Oregon Act*. December 2007.

## **PCPCH Core Attributes and Standards**

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

Figure 1: Core Attributes of Patient Centered Primary Care Homes



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

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



Figure 2: Patient Centered Primary Care Home Standards

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

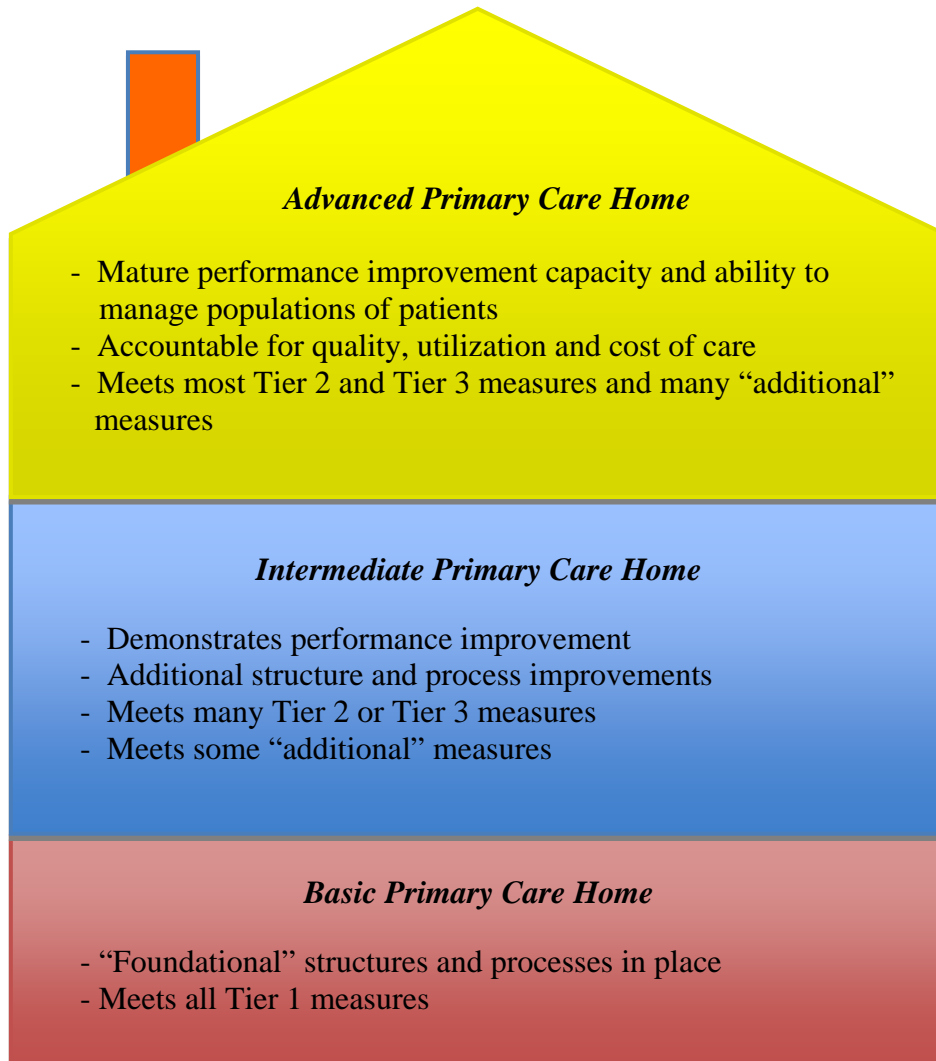
The committee used the basic framework of its core attributes and standards to develop a more detailed set of PCPCH measures. The proposed measures provide a specific blueprint for the changes needed to move from today’s primary care system to a more ideally functioning system. Unlike the core attributes and standards, the proposed measures are not aspirational. They are intended as a functional tool that can be used to recognize clinics currently delivering some primary care home functions and support payment reform or other incentives that will drive an increasing number of clinics towards functioning as advanced primary care homes.

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

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

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

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



### **Guiding Principles**

The HFB and others have recognized that current delivery system is not sustainable and does not produce optimal health or health care for Oregonians. However, the committee expressed concerns that primary care is among the most vulnerable components of the health care delivery system and faces a variety of challenges, including a declining workforce, increased fragmentation of care, high administrative burdens and many unpaid services. While the committee felt that thoughtful and gradual movement towards the care model envisioned in the proposed PCPCH measures could produce the benefits envisioned by the HFB, they also expressed concern that mis-application of the proposed measures could worsen the current challenges facing primary care, especially in rural and underserved communities in Oregon.

The PCPCH Standards Advisory Committee recommends that the Oregon Health Authority and others consider the following guiding principles in the application of the proposed standards and

measures for Patient Centered Primary Care Homes. Guiding principles are divided into five broad categories: strategies for payment reform, providing incentives for delivery system change, strategies for primary care home measurement, encouraging continuous improvement, and aligning the health care system around primary care homes.

### ***Strategies for Payment Reform***

1. Payment reform is an essential step for developing Primary Care Homes. Currently, primary care clinics use fee-for-service payments to fund essential but unpaid primary care functions such as care coordination. The current payment model fails to recognize the complexity and intensity of primary care, devalues the work of all members of the primary care team, contributes to overwork and burnout of clinicians, does not assess and reward quality care, and decreases opportunities for meaningful communication between patients and their health care team.
2. The basic Primary Care Home functions proposed in the attached standards and measures (tier 1) may require changes to the existing care delivery model, but should be achievable by most primary care clinics in Oregon (regardless of size, patient mix or geographic location). Additional resources will be required for clinics to achieve many advanced (tier 2 and tier 3) Primary Care Home functions. Requiring primary care clinics to meet advanced Primary Care Home measures without additional resources or an adequate workforce will exacerbate existing workforce shortages and could worsen health disparities in underserved populations.
3. Payment for Primary Care Homes should be risk-adjusted based on a broad set of factors that increase the complexity of delivering and coordinating care (e.g. medical complexity, primary language, socioeconomic factors, rates of behavioral risk factors and mental illness, etc.). Risk-adjusted payment models should include adequate payments for all patients, including those in the lowest risk groups.
4. Payment mechanisms for Primary Care Homes should include both ongoing payments that adequately support Primary Care Home infrastructure (systems, staffing, etc.) and incentive payments based on outcomes.
5. It is reasonable to expect advanced (tier 3) Primary Care Homes to be accountable, in part, for unnecessary or preventable utilization and the risk-adjusted overall cost of health care within their patient populations. A common set of cost and utilization measures should be developed and applied consistently across payers (see possible measures below). These measures should be based on a primary care home's entire patient population, should be appropriate to that population, and should be risk adjusted as discussed above. In addition, primary care clinics must have timely access to patient-level cost and utilization data for care delivered outside the Primary Care Home.

Examples of standardized utilization measures could include:

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

Examples of standardized cost of care measures could include:

- Total cost of care for pts with certain chronic diseases
- Cost of care in last 6 months of life
- Cost of specialty care
- Cost of diagnostic imaging
- Cost of medications

### ***Providing Incentives for Delivery System Change***

6. The Oregon Health Fund Board felt that providing a Primary Care Home for every Oregonian could move Oregon's health care system towards the "triple aim" goals of a healthy population, extraordinary patient care and reasonable costs. Achieving these goals will require moving the entire primary care delivery system towards functioning as "advanced" Primary Care Homes.
7. Primary Care Home measures are intended to be applied to an entire clinic or all patients served by a clinic, regardless of whether patients are publically or privately insured. Care coordination and other services provided by a Primary Care Home are of potential benefit to all patients, not just those with specific chronic diseases.
8. Any clinic that is willing to assume responsibility for providing comprehensive, longitudinal care to a population of patients (such as a community mental health center) should be eligible to be measured and receive payments as a Primary Care Home.
9. Primary Care Home payments and incentives should reward both current levels of high performance and incremental delivery system changes.

### ***Strategies for Primary Care Home Measurement***

10. Primary Care Home measures should be applied consistently across public and private health plans, to provide clinics with a uniform set of expectations, but with some flexibility in how clinics can demonstrate they are meeting the intent of particular measures.
11. The process of Primary Care Home measurement should seek to minimize the administrative burden on and cost to individual clinics and provide constructive feedback to primary care clinics. Purchasers should consider measuring and/or recognizing primary care homes through a single, centralized entity that forms a positive relationship with primary care practices. The Ambulatory Records Certification (ARC) collaborative developed by the Oregon Medical Association (OMA) in the 1990's was a successful Oregon example of such an entity.
12. Evaluation criteria for Primary Care Homes should be transparent to all parties, including consumers, clinics, health plans and purchasers.
13. Primary Care Home performance and improvement over time should be measured using internal clinical data, such as data directly from a clinic's electronic health record, in addition to external data such as claims data whenever possible.

### ***Encouraging Continuous Improvement***

14. The measures of Primary Care Home roles and functions should evolve over time as the delivery system changes and successful new models of care emerge. The state should establish a process to regularly review and update Primary Care Home standards and measures. A number of important areas should be should be considered in the development of future measures, including:
  - Cultural competency
  - Integration of physical health, mental health and addiction services
  - Understanding patients in context (social history and impacts on health)
  - Roles of the primary care home in community health improvement and public health
  - Involving patients and families in the primary care home
15. Learning collaboratives and other mechanisms to spread learning and speed delivery system change and integration should be developed and financed in conjunction with efforts to measure Primary Care Homes. Primary care clinics should receive support for participation in learning collaboratives, especially those clinics that are early adopters of the Primary Care Home model and can share their learning with others.
16. Developing Primary Care Homes will require clinicians and staff of primary care clinics to develop new skills and take on new roles as members of a primary care team. Efforts to improve the primary care workforce must include both support for continuing education of current clinicians and clinic staff and changes in training programs that produce the future primary care workforce.

### ***Aligning the Health System Around Primary Care Homes***

17. Communication within the health care system is critical to the success of Primary Care Homes. Other health care providers and facilities should be required to identify each patient's Primary Care Home, communicate with the Primary Care Home in a timely manner, and participate in care coordination.
18. A robust "health care neighborhood" is required to support the Primary Care Home. Primary Care Homes should be encouraged to partner with local public health agencies and community organizations to educate patients, identify community health priorities, and develop plans to improve the overall health of their communities. Public Health departments and other agencies and organizations that make up the "health care neighborhood" must have sufficient and stable funding to carry out these roles.
19. Primary Care Home measurement should be integrated and aligned with other efforts to improve health care quality or delivery (e.g. health information technology incentives, quality improvement programs, pay for performance incentives and development of accountable care organizations).

**Patient Centered Primary Care Home - Standards Advisory Committee**  
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## **Proposed Core Attributes and Standards for Patient Centered Primary Care Homes**

### **Core Attribute: ACCESS TO CARE**

*Be there when I need you.*

- Make it easy for me to get care and advice when I need and want it for myself and my family members.
- Provide flexible, responsive options for me to get care in a timely way.

#### **Standard: In-Person Access**

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

#### **Standard: Telephone and Electronic Access**

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

#### **Standard: Administrative Access**

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

### **Core Attribute: ACCOUNTABILITY**

*Take responsibility for making sure I receive the best possible health care.*

#### **Standard: Performance Improvement**

- Work to improve the care and services you provide and ask me for feedback and ideas about what to improve.
- Publically report information about the safety, quality and cost of the care you provide.
- Show me what you are doing to ensure I will get the right care while avoiding unnecessary care.

#### **Standard: Cost and Utilization**

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

### **Core Attribute: COMPREHENSIVE WHOLE PERSON CARE**

*Provide or help me get the health care and services I need.*

- Help me get prevention services, acute care, care for ongoing problems, and help for mental health conditions or problems with substance or alcohol use.
- Help me understand my health risks and/or conditions and give me tools and support to manage my own care.

#### **Standard: Scope of Services**

- Provide most of the care I need for common problems at your clinic.



**Core Attribute: CONTINUITY**

***Be my partner over time in caring for my health.***

- Let me choose my personal clinician.
- Know who I am and remember important information about my health history, needs and values.
- Help me make well-informed decisions about my health and health care.

**Standard: Provider Continuity**

- Make sure I can choose a personal clinician and health care team who know and understand me.
- Make sure I can see or talk with my chosen personal clinician or team whenever I need to.

**Standard: Information Continuity**

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

**Standard: Geographic Continuity**

- Stay involved in my care wherever I go within the health care system, and help me to coordinate my care across places and people.

**Core Attribute: COORDINATION AND INTEGRATION**

***Help me navigate the health care system to get the care I need in a safe and timely way.***

- Make sure I understand what care or services I need to stay healthy and manage my medical and mental health problems and where to get them.
- Stay involved in my care and help me to avoid unnecessary tests, procedures or interventions.

**Standard: Data Management**

- Follow my care closely and let me know when tests or checkups are needed.
- Make sure I understand which tests, prevention services and lifestyle changes are recommended to improve my health.

**Standard: Care Coordination**

- When I need to go to other providers or places for care or services, help me coordinate and plan my care without delays and confusion.
- When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.
- Make sure I understand the reasons for sending me to a specialist or for a test, prepare me for what to expect and follow up with me afterwards to make sure I understand the results.

**Standard: Care Planning**

- Help me and my family set goals and plan for my care in a way that is understandable and meets my needs.
- Provide me with the information I need to care for my own illness and challenge me to actively care for myself.

**Core Attribute: PERSON AND FAMILY CENTERED CARE**

*Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.*

- Listen to me and my family members or caregivers and promote experiences that enhance my independence and control over my health.
- Respect my culture and values and build a relationship with me that is responsive to my needs and preferences.

**Standard: Communication**

- Communicate in the language that my family members and I can understand.
- Explain things in ways that make it easy for my family members and I to understand and check to be sure we understand.
- Share information with me in an unbiased way.

**Standard: Education and Self-Management Support**

- Respect my capacity to learn and engage me and my family members as partners in managing my health.
- Help me know what I need to do to manage and maintain my health.
- Invite me to set goals for improving my health and support my efforts to change my behavior to improve my health and wellness.

**Standard: Experience of Care**

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

Appendix C – Overview of Proposed Patient Centered Primary Care Home Measures by Tier

**Tier 1 Primary Care Home (PCH) Measures**

Access to Care	<p><u>Appointment Access</u>: PCH tracks and reports a standard measure of appointment access.</p> <p><u>After Hours Appointments</u>: PCH offers appointments at least 4 hours weekly outside traditional business hours.</p> <p><u>Telephone Advice</u>: PCH provides continuous access to clinical advice by telephone.</p>
Accountability	<p><u>Performance Improvement</u>: PCH tracks at least three performance indicators and reports goals for improvement.</p>
Comprehensive Whole Person Care	<p><u>Preventive Services</u>: PCH offers a certain percentage of recommended preventive services.</p> <p><u>Medical Services</u>: PCH offers acute care, chronic care, procedures, patient education, and end of life counseling.</p> <p><u>Mental Health and Substance Abuse Services</u>: PCH documents its screening strategy for mental health and substance use conditions AND documents on-site and local referral resources.</p> <p><u>Health Risk Behaviors</u>: PCH documents routine assessment and intervention for at least 3 health risk behaviors.</p>
Continuity	<p><u>Personal Clinician Assignment</u>: PCH reports the % of active patients assigned a personal clinician and team.</p> <p><u>Personal Clinician Continuity</u>: PCH reports patients' usual provider continuity with their personal clinician/team.</p> <p><u>Organization of Clinical Information</u>: PCH maintains an up-to-date health record containing certain elements.</p> <p><u>Specialized Care Settings</u>: PCH has a written agreement with its usual hospital providers.</p>
Coordination and Integration	<p><u>Population Data Management</u>: PCH demonstrates the ability to reliably identify, track and proactively manage the care needs of a sub-population of its patients.</p> <p><u>Care Coordination</u>: PCH assigns individual responsibility for care coordination for each patient.</p> <p><u>Test and Result Tracking</u>: PCH tracks ordered tests and notifies patients and clinicians of results.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH either manages hospital and nursing facility care or demonstrates active involvement and coordination of care when its patients receive care in these specialized settings.</p> <p><u>Comprehensive Care Planning</u>: PCH demonstrates that it can provide all patients with a written care summary.</p> <p><u>End of Life Planning</u>: PCH offers patients the opportunity to complete a POLST or advanced directive.</p>
Person and Family Centered Care	<p><u>Roles and Responsibilities</u>: PCH educates patients about PCH and patient roles and responsibilities.</p> <p><u>Interpreter Services</u>: PCH communicates with patients in their language of choice.</p> <p><u>Education and Self-Management Support</u>: PCH documents patient and family education and self-management support efforts, including available community resources.</p> <p><u>Patient Experience Survey</u>: PCH surveys its patients at least annually on their experience of care.</p>

Appendix C – Overview of Proposed Patient Centered Primary Care Home Measures by Tier

**Tier 2 Primary Care Home (PCH) Measures**

Access to Care	<u>Appointment Access</u> : PCH sets a goal for improving an appointment access measure and demonstrates improvement.
Accountability	<u>Performance Improvement</u> : PCH demonstrates improvement towards its reported goals on at least three performance indicators. <u>Public Reporting</u> : PCH publically reports practice-level clinical quality indicators to an external entity.
Comprehensive Whole Person Care	<u>Mental Health and Substance Abuse Services</u> : PCH documents direct collaboration or co-management of patients with a specialty mental health and substance abuse provider.
Continuity	<u>Personal Clinician Assignment</u> : PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team. <u>Personal Clinician Continuity</u> : PCH meets a benchmark or demonstrates improvement in patients' usual provider continuity with their assigned personal clinician and team. <u>Specialized Care Settings</u> : PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge.
Coordination and Integration	<u>Care Coordination</u> : PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. <u>Comprehensive Care Planning</u> : PCH demonstrates the ability to identify high-risk individuals and demonstrates that it can provide these individuals with a written care plan containing specific elements. <u>End of Life Planning</u> : PCH meets a benchmark or demonstrates improvement in the percentage of patients age 65 or older who are offered the opportunity to complete a POLST.
Person and Family Centered Care	<u>Communication of Patient and PCH Expectations</u> : PCH meets benchmark of the percentage of active patients who have received educational materials on PCH and patient roles and responsibilities. <u>Patient Experience Survey</u> : PCH demonstrates using the results of its patient experience survey to improve care.

Appendix C – Overview of Proposed Patient Centered Primary Care Home Measures by Tier

**Tier 3 Primary Care Home (PCH) Measures**

Access to Care	<u>Appointment Access</u> : PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to appointments on a patient experience survey.
Accountability	<u>Clinical Quality Improvement</u> : PCH demonstrates improvement in a certain number of clinical quality indicators. PCHs achieving a benchmark level of performance on a given indicator would be required to maintain excellent performance, but not demonstrate continued improvement.
Comprehensive Whole Person Care	<u>Mental Health and Substance Abuse Services</u> : PCH documents actual or virtual co-location with specialty mental health and substance abuse providers.
Continuity	<u>Clinical Information Exchange</u> : PCH shares clinical information electronically in real time with other health care providers.
Coordination and Integration	<u>Electronic Health Record</u> : PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules. <u>Comprehensive Care Planning</u> : PCH measures and demonstrates improvement in the percentage of high-risk individuals with a written care plan that has been updated in the past year.
Person and Family Centered Care	<u>Patient Experience Survey</u> : PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics.

Appendix C – Overview of Proposed Patient Centered Primary Care Home Measures by Tier

**Additional Primary Care Home (PCH) Measures**

<p>Access to Care</p>	<p><u>After Hours Appointments</u>: PCH offers appointments 8 or more hours weekly outside traditional business hours.</p> <p><u>Telephone Advice</u>: Telephone encounters (including after hours) are documented in the patient’s medical record.</p> <p><u>Telephone Advice</u>: PCH tracks and improves the time required to resolve telephone requests for clinical advice.</p> <p><u>Electronic Access</u>: PCH provides at least one option for electronic access, such as e-mail or a “web portal.”</p> <p><u>Prescription Refills</u>: PCH tracks and improves the % prescription refill requests completed within 48 hours.</p>
<p>Accountability</p>	<p><u>Ambulatory Sensitive Utilization</u>: PCH demonstrates risk-adjusted reductions in utilization measures or excellent performance across its patient population according to prior performance or a risk-adjusted community standard.</p>
<p>Comprehensive Whole Person Care</p>	<p><u>Health Risk Behaviors</u>: PCH improves its rates of intervention for a given health risk behavior.</p> <p><u>Health Risk Behaviors</u>: PCH reduces the percentage of its patients with a given health risk behavior.</p>
<p>Continuity</p>	<p><u>Clinical Information Exchange</u>: PCH transmits data to patients’ electronic personal health records or provides an electronic means for patients to access their personal health information in real time.</p> <p><u>Specialized Care Settings</u>: PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department.</p>
<p>Coordination and Integration</p>	<p><u>Population Data Management</u>: PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients.</p> <p><u>Care Coordination</u>: PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions.</p> <p><u>Test and Result Tracking</u>: PCH demonstrates tracking planned or indicated tests and generating reminders for patients and clinicians.</p> <p><u>Referral and Specialty Care Coordination</u>: PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receiving ongoing specialty care outside the PCH.</p>
<p>Person and Family Centered Care</p>	<p><u>Education and Self-Management Support</u>: PCH assesses patients’ activation or readiness to change (as appropriate) and uses this information to improve patient education and self-management.</p> <p><u>Education and Self-Management Support</u>: PCH tracks and improves the percentage of patients with a particular chronic condition (e.g. diabetes) who have been offered education or self-management support.</p> <p><u>Education and Self-Management Support</u>: PCH demonstrates active follow up with patients regarding their self-management goals.</p>

### Proposed Measures for Patient Centered Primary Care Homes

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

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

#### Core Attribute: ACCESS TO CARE

##### *Be there when I need you.*

- Make it easy for me to get care and advice when I need and want it for myself and my family members.
- Provide flexible, responsive options for me to get care in a timely way.

##### **Standard: In-Person Access**

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

##### **Access Measure 1: Appointment Access**

PCH tracks and improves access to appointments in the clinic and patient satisfaction with appointment access.

**Tier 1:** PCH tracks and reports a standard measure of appointment access.

**Tier 2:** PCH sets a specific goal for improving an appointment access measure and demonstrates improvement.

**Tier 3:** PCH meets a benchmark or demonstrates improvement in the percentage of patients reporting high satisfaction with access to appointments on a patient experience survey (See also Person-Centered Measure #4).

##### **Access Measure 2: After Hours Appointments**

PCH offers appointments outside of traditional business hours (8:00am - 5:00pm, M-F).

**Tier 1:** PCH offers appointments at least 4 hours weekly outside traditional business hours.

**Additional Measure:** PCH offers appointments 8 or more hours weekly outside traditional business hours.

<b>Core Attribute: ACCESS TO CARE</b>
<b>Standard: Telephone and Electronic Access</b> <ul style="list-style-type: none"><li>• Make sure I know what to do if I need or want help when your office is closed.</li><li>• Provide multiple ways for me to easily get care or advice outside of office visits.</li></ul>
<b>Access Measure 3: Telephone Advice</b> <p>PCH provides telephone access to a clinician for advice 24 hours a day and tracks and improves telephone care.</p> <p><b>Tier 1:</b> PCH provides continuous access to clinical advice by telephone.</p> <p><b>Additional Measure:</b> Telephone encounters (including after hours encounters) are documented in the patient’s medical record.</p> <p><b>Additional Measure:</b> PCH tracks and improves the time required to resolve telephone requests for clinical advice.</p>
<b>Access Measure 4: Electronic Access</b> <p>PCH provides an option for patients to access care, clinical advice and test results in an electronic format.</p> <p><b>Additional Measure:</b> PCH provides at least one option for electronic access, such as secure e-mail or a secure “web portal” (See also Continuity Measure #4)</p>
<b>Standard: Administrative Access</b> <ul style="list-style-type: none"><li>• Respond to my requests for help with refills, paperwork, etc. in the most efficient way possible to meet my needs.</li></ul>
<b>Access Measure 5: Prescription Refills</b> <p>PCH responds promptly to patient requests for prescription refills.</p> <p><b>Additional Measure:</b> PCH tracks the percentage of prescription refill requests completed within 48 hours and meets a benchmark or demonstrates improvement in this percentage over time.</p>



<b>Core Attribute: ACCOUNTABILITY</b>
<i>Take responsibility for making sure I receive the best possible health care.</i>
<b>Standard: Performance Improvement</b> <ul style="list-style-type: none"> <li>• Work to improve the care and services you provide and ask me for feedback and ideas about what to improve.</li> <li>• Publically report information about the safety, quality and cost of the care you provide.</li> <li>• Show me what you are doing to ensure I will get the right care while avoiding unnecessary care.</li> </ul>
<b>Accountability Measure 1: Performance Improvement</b> PCH measures its own performance, sets goals and improves its care over time. <b>Tier 1:</b> PCH tracks at least three performance indicators* and reports goals for improvement. <b>Tier 2:</b> PCH demonstrates improvement towards its reported goals on at least three performance indicators. *Performance indicators could be defined by the PCH across a range of domains, such as clinical processes, clinical outcomes or patient or staff satisfaction (See also Access Measures #1,3&5; Comprehensive Measure #4, Continuity Measures #1,2&5; Coordination Measures #1,4,5,6&7; and Person-Centered Measures #1,3&4).
<b>Accountability Measure 2: Clinical Quality Improvement</b> PCHs improve clinical quality indicators* in their patient population. <b>Tier 3:</b> PCH demonstrates improvement in a certain number of clinical quality indicators. PCHs achieving a benchmark level of performance on a given indicator would be required to maintain excellent performance, but not demonstrate continued improvement. * PCHs should have the ability to select quality measures most relevant to their patient population from a pre-established statewide set of nationally accepted quality measures.
<b>Accountability Measure 3: Public Reporting</b> PCH participates in a program of voluntary public reporting of practice-level clinical quality indicators (e.g. reporting of performance indicators to a health plan, Medicare or Medicaid, the State, or the Oregon Quality Corporation). <b>Tier 2:</b> PCH publically reports practice-level clinical quality indicators to an external entity.
<b>Standard: Cost and Utilization</b> <ul style="list-style-type: none"> <li>• Keep me informed about the relative costs, benefits and risks of the different options for my care so I can make informed decisions.</li> <li>• Do not prescribe tests, medications, procedures or referrals that are unnecessary or do not improve my quality of life.</li> </ul>

**Core Attribute: ACCOUNTABILITY**

**Accountability Measure 4: Ambulatory Sensitive Utilization**

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

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

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

<b>Core Attribute: COMPREHENSIVE WHOLE PERSON CARE</b>
<b><i>Provide or help me get the health care and services I need.</i></b> <ul style="list-style-type: none"><li>• Help me get prevention services, acute care, care for ongoing problems, and help for mental health conditions or problems with substance or alcohol use.</li><li>• Help me understand my health risks and/or conditions and give me tools and support to manage my own care.</li></ul>
<b>Standard: Scope of Services</b> <ul style="list-style-type: none"><li>• Provide most of the care I need for common problems at your clinic.</li></ul>
<b>Comprehensive Measure 1: Preventive Services</b> <p>PCH offers most age and gender appropriate preventive services, including the following: USPSTF recommended services, ACIP recommended vaccinations and developmental screening in infancy and early childhood.</p> <p><b>Tier 1:</b> PCH reports, using a checklist, that it offers a certain percentage of recommended preventive services.</p>
<b>Comprehensive Measure 2: Medical Services</b> <p>PCH offers a broad range of medical services to meet the care needs of its patient population within the PCH as often as possible.</p> <p><b>Tier 1:</b> PCH reports that it routinely offers all of the following categories of services:</p> <ul style="list-style-type: none"><li>▪ Acute care for minor illnesses and injuries</li><li>▪ Ongoing management of chronic diseases</li><li>▪ Office-based procedures and diagnostic tests</li><li>▪ Patient education and self-management support</li><li>▪ Advice and counseling on end of life issues (adult only)</li></ul>
<b>Comprehensive Measure 3: Mental Health and Substance Abuse Services</b> <p>PCH routinely offers care for mental health and substance use disorders, including all of the following: screening, diagnosis, management and appropriate referral to specialty services.</p> <p><b>Tier 1:</b> PCH documents its screening strategy for mental health and substance use conditions AND documents on-site and local referral resources.</p> <p><b>Tier 2**:</b> PCH documents direct collaboration or co-management of patients with specialty mental health and substance abuse providers.</p> <p><b>Tier 3**:</b> PCH documents actual or virtual co-location with specialty mental health and substance abuse providers.</p> <p>** Practices could be exempt from Tier 2 and 3 measures if a shortage of mental health or substance abuse providers or services exists within their geographic area or for their patient population.</p>

**Core Attribute: COMPREHENSIVE WHOLE PERSON CARE**

**Comprehensive Measure 4: Health Risk Behavior Assessment and Intervention**

The PCH routinely assesses common health risk behaviors in its population and offers interventions to support behavior change. Examples of common health risk behaviors include, but are not limited to: alcohol or drug use, tobacco use, obesity, physical inactivity, injury or violence, nutrition and sexual risk behaviors.

**Tier 1:** PCH documents routine assessment and intervention for at least three health risk behaviors.

**Additional Measure:** PCH documents improvement in its rates of intervention for a given health risk behavior (e.g. increase in referral rates for alcohol treatment among documented users).

**Additional Measure:** PCH documents reduction of the percentage of its patients with a given health risk behavior over time (e.g. decrease in the percentage of active smokers).

<b>Core Attribute: CONTINUITY</b>
<b><i>Be my partner over time in caring for my health.</i></b> <ul style="list-style-type: none"><li>• Let me choose my personal clinician.</li><li>• Know who I am and remember important information about my health history, needs and values.</li><li>• Help me make well-informed decisions about my health and health care.</li></ul>
<b>Standard: Provider Continuity</b> <ul style="list-style-type: none"><li>• Make sure I can choose a personal clinician and health care team who know and understand me.</li><li>• Make sure I can see or talk with my chosen personal clinician or team whenever I need to.</li></ul>
<b>Continuity Measure 1: Personal Clinician Assignment</b> <p>The PCH assigns individuals to a personal clinician and primary care team using individual and family choice as the primary guiding principle.</p> <p><b>Tier 1:</b> PCH reports the percentage of active patients assigned a personal clinician and team.</p> <p><b>Tier 2:</b> PCH meets a benchmark or demonstrates improvement in the percentage of active patients assigned to a personal clinician and team.</p>
<b>Continuity Measure 2: Personal Clinician Continuity</b> <p>The PCH tracks and seeks to improve patients' continuity with their chosen personal clinician and primary care team.</p> <p><b>Tier 1:</b> PCH reports patients' usual provider continuity* with their assigned personal clinician or a team member.</p> <p><b>Tier 2:</b> PCH meets a benchmark or demonstrates improvement in patients' usual provider continuity* with their assigned personal clinician and team.</p> <p>* Usual Provider Continuity = visits with personal clinician or a team member/total patient visits.</p>
<b>Standard: Information Continuity</b> <ul style="list-style-type: none"><li>• Make sure that all health professionals caring for me have access to up-to-date and accurate information about my health history and values.</li><li>• Ensure that my personal health information is always protected and kept private.</li><li>• Make it easy for me to access my personal health information.</li></ul>

<b>Core Attribute: CONTINUITY</b>
<b>Continuity Measure 3: Organization of Clinical Information</b> PCH maintains up-to-date and accurate records and organizes clinical information in a way that is easily shared with and understandable by health care professionals inside and outside the PCH. Maintaining accurate and up-to-date health records is an essential prerequisite for care coordination and care planning (See Coordination Measure #2 and #6). <b>Tier 1:</b> PCH maintains a health record for each patient that contains at least the following elements (problem list, medication list, allergies, basic demographic information and preferred language) and updates this record as needed at each visit.
<b>Continuity Measure 4: Clinical Information Exchange</b> PCH demonstrates timely and confidential exchange of important clinical information with hospitals and consultants and provides patients with electronic access to their health information. <b>Tier 3:</b> PCH shares clinical information electronically in real time with other health care providers (electronic health information exchange). <b>Additional Measure:</b> PCH demonstrates that it transmits data to patients' electronic personal health records or provides an electronic means for patients to access their personal health information in real time (See also Access Measure #4).
<b>Standard: Geographic Continuity</b> <ul style="list-style-type: none"><li>Stay involved in my care wherever I go within the health care system, and help me to coordinate my care across places and people.</li></ul>
<b>Continuity Measure 5: Specialized Care Settings</b> PCH tracks when its patients are cared for in specialized care settings (e.g. hospital, nursing facility or other residential treatment) and is actively involved during and after care in these settings (See also Coordination Measure #5). <b>Tier 1:</b> PCH has a written agreement with its usual hospital providers or directly provides routine hospital care. <b>Tier 2:</b> PCH meets benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of hospital discharge. <b>Additional Measure:</b> PCH meets a benchmark or demonstrates improvement in the percentage of patients seen or contacted within 1 week of discharge from an Emergency Department.

<b>Core Attribute: COORDINATION AND INTEGRATION</b>
<p><b><i>Help me navigate the health care system to get the care I need in a safe and timely way.</i></b></p> <ul style="list-style-type: none"><li>• Make sure I understand what care or services I need to stay healthy and manage my medical and mental health problems and where to get them.</li><li>• Stay involved in my care and help me to avoid unnecessary tests, procedures or interventions.</li></ul>
<p><b>Standard: Data Management</b></p> <ul style="list-style-type: none"><li>• Follow my care closely and let me know when tests or checkups are needed.</li><li>• Make sure I understand which tests, prevention services and lifestyle changes are recommended to improve my health.</li></ul>
<p><b>Coordination Measure 1: Population Data Management</b></p> <p>PCH uses a system to organize, track and improve the care of sub-populations of its patients* with specific care needs (See also Coordination Measure #2).</p> <p><b>Tier 1:</b> PCH demonstrates the ability to reliably identify, track and proactively manage** the care needs of a sub-population of its patients.</p> <p><b>Additional Measure:</b> PCH demonstrates the use of its population data management system to improve a specific care indicator within a sub-population of its patients.</p> <p>*PCHs may choose to create lists or registries of sub-populations based on a variety of conditions (e.g. diabetes or pregnancy) or demographic characteristics (e.g. children &lt; age 1 or women).</p> <p>**Proactive management could be demonstrated through the use of a list or registry to track and improve care delivery through strategies such as care protocols and patient or clinician reminders.</p>
<p><b>Coordination Measure 2: Electronic Health Record</b></p> <p>PCH has an electronic health record (EHR) and uses this tool to improve patient care.</p> <p><b>Tier 3:</b> PCH has an electronic health record and demonstrates “meaningful use” of the electronic record, according to CMS rules.</p>
<p><b>Standard: Care Coordination</b></p> <ul style="list-style-type: none"><li>• When I need to go to other providers or places for care or services, help me coordinate and plan my care without delays and confusion.</li><li>• When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.</li><li>• Make sure I understand the reasons for sending me to a specialist or for a test, prepare me for what to expect and follow up with me afterwards to make sure I understand the results.</li></ul>

<b>Core Attribute: COORDINATION AND INTEGRATION</b>
<p><b>Coordination Measure 3: Care Coordination</b></p> <p>PCH assigns individual responsibility for care coordination for each patient to a member of the health care team. Care coordination functions might include the following:</p> <ul style="list-style-type: none"><li>- coordination of care received outside the PCH and in specialized care settings</li><li>- tracking of indicated care and tests</li><li>- self management support and education</li><li>- motivational interviewing and coaching on behavior change</li></ul> <p><b>Tier 1:</b> PCH assigns individual responsibility for care coordination and tells each patient the name of the team member responsible for coordinating his or her care.</p> <p><b>Tier 2:</b> PCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.</p> <p><b>Additional Measure:</b> PCH demonstrates that members of the health care team acting as care coordinators for patients with complex care needs have received specific training in care coordination functions.</p>
<p><b>Coordination Measure 4: Test and Result Tracking</b></p> <p>PCH tracks laboratory and imaging tests and follows up on results.</p> <p><b>Tier 1:</b> PCH demonstrates tracking tests ordered by its clinicians and ensures timely notification of results to patients and clinicians.</p> <p><b>Additional Measure:</b> PCH demonstrates tracking planned or indicated tests and generating reminders for patients and clinicians.</p>
<p><b>Coordination Measure 5: Referral and Specialty Care Coordination</b></p> <p>PCH tracks and coordinates the care its patients receive outside the PCH.</p> <p><b>Tier 1:</b> PCH demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians.</p> <p><b>Tier 1:</b> PCH either manages hospital and skilled nursing facility care for its patients or demonstrates active involvement and coordination of care when its patients receive care in these specialized care settings (See also Continuity Measure #5).</p> <p><b>Additional Measure:</b> PCH demonstrates collaborative care planning with other health care professionals and patients and their families when patients receive ongoing specialty care outside the PCH.</p>
<p><b>Standard: Care Planning</b></p> <ul style="list-style-type: none"><li>• Help me and my family set goals and plan for my care in a way that is understandable and meets my needs.</li><li>• Provide me with the information I need to care for my own illness and challenge me to actively care for myself.</li></ul>



**Core Attribute: COORDINATION AND INTEGRATION**

**Coordination Measure 6: Comprehensive Care Planning**

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

**Tier 1:** PCH demonstrates that it can provide all patients with a written care summary that includes the following:

- current problem list, medication list and allergies (See also Continuity Measure #3)
- indicated preventive care
- goals of preventive and chronic illness care

**Tier 2:** PCH demonstrates the ability to identify high-risk individuals\* who need and will benefit from additional care planning. PCH demonstrates that it can provide these individuals with a written care plan that includes the following:

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

**Tier 3:** PCH measures and demonstrates improvement in the percentage of high-risk individuals\* who have a written care plan that has been reviewed with the patient and/or caregivers in the past year.

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

**Coordination Measure 7: End of Life Planning**

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

**Tier 1:** PCH documents offering patients the opportunity to complete a POLST form or advanced directive (when appropriate) AND attests to submitting completed POLST forms to the Oregon POLST registry (unless patients opt out).

**Tier 2:** PCH meets a benchmark or demonstrates improvement in the percentage of patients age 65 or older who are offered the opportunity to complete a POLST.

**Core Attribute: PERSON AND FAMILY CENTERED CARE**

***Recognize that I am the most important member of my care team - and that I am ultimately responsible for my overall health and wellness.***

- Listen to me and my family members or caregivers and promote experiences that enhance my independence and control over my health.
- Respect my culture and values and build a relationship with me that is responsive to my needs and preferences.

**Standard: Communication**

- Communicate in the language that my family members and I can understand.
- Explain things in ways that make it easy for my family members and I to understand and check to be sure we understand.
- Share information with me in an unbiased way.

**Person Measure 1: Communication of Roles and Responsibilities**

PCH communicates with its patients about the roles and responsibilities of the PCH and patients.

**Tier 1:** PCH has a written document or other educational materials that outline PCH and patient roles and responsibilities and documents (e.g. through a patient signature) that this information has been communicated to each patient or a family member/caregiver. Educational materials should contain at least the following information: options for accessing care, names of primary care team members, information on care planning and care coordination and information on patient responsibilities.

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

**Person Measure 2: Interpreter Services**

PCH communicates with patients in their language of choice.

**Tier 1:** PCH documents the use of either providers who speak a patient's language or real time face-to-face or telephonic interpreters to communicate with patients in their language of choice.

**Standard: Education and Self-Management Support**

- Respect my capacity to learn and engage me and my family members as partners in managing my health.
- Help me know what I need to do to manage and maintain my health.
- Invite me to set goals for improving my health and support my efforts to change my behavior to improve my health and wellness.

**Core Attribute: PERSON AND FAMILY CENTERED CARE**

**Person Measure 3: Education and Self-Management Support**

PCH offers education and self-management support to patients and their families and caregivers who would benefit from such services. Education and self management support should include the following:

- information about basic diagnosis, prognosis, exacerbations and/or treatment of conditions
- strategies for self-management of chronic conditions to change the course of illness and improve health
- community or written resources or support group contacts (when appropriate).

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

**Additional Measure:** PCH assesses patients' activation or readiness to change (as appropriate) and uses this information to improve patient education and self-management.

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

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

**Standard: Experience of Care**

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

**Person Measure 4: Patient Experience Survey**

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

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

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

**Tier 3:** PCH collects and reports patient experience data using a standardized survey that can be used to compare patient experience across clinics (See also Access Measure #1).