Table 1. Recognition Criteria for Patient Centered Primary Care Homes

PCPCH CORE ATTRIBUTE		
PCPCH Standard		
PCPCH Measures	**Must Pass**	**Points Available**
ACCESS TO CARE		
Standard 1.A) In-Person Access		
1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams. (A)	No	5
1.A.2 PCPCH regularly tracks timely access and communication to clinical staff and care teams, and has an improvement plan in place to improve their outcomes. (A)	No	10
Standard 1.B) After Hours Access		
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours. (A)	No	5
Standard 1.C) Telephone & Electronic Access		
1.C.0 PCPCH provides continuous access to clinical advice by telephone. (A)	**Yes**	0
Standard 1.D) Same Day Access		
1.D.1 PCPCH provides same day appointments.	No	5
Standard 1.E) Electronic Access		
1.E.1 PCPCH provides patients with access to an electronic copy of their health information.	No	5

(A)= Attestation (D) = Data must be submitted

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Standard 1.F) Prescription Refills		
1.F.2 PCPCH tracks the time to completion for prescription refills. (A)	No	10
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription. (A)	No	15
Standard 1.G) Alternative Access[1]		
1.G.1 PCPCH regularly communicates with patients through a patient portal.	No	5
1.G.2 PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.	No	10
ACCOUNTABLITY		
Standard 2.A) Performance & Clinical Quality[2]		
2.A.0 PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures. (A)[3]	**Yes**	0
2.A.1 PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes three measures from the set of PCPCH Quality Measures. (D)	No	5
2.A.3 PCPCH tracks, reports to the OHA, and demonstrates a combination of improvement and meeting benchmarks on three of the PCPCH Quality measures. (D)	No	15
Standard 2.B) Public Reporting		
2.B.1 PCPCH participates in a public reporting program for performance indicators and data collected for public reporting programs is shared with providers and staff within the PCPCH. (A)	No	5
Standard 2.C) Patient and Family Involvement in Quality Improvement		
2.C.1 PCPCH involves patients, families, and caregivers, as advisors on at least one quality or safety initiative per year. (A)	No	5

[1] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)
[2] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)
[3] See Table 2 for the list of PCPCH Quality Measures

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development and/or educational improvement activities. (A)	No	10
2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or in training roles. (A)	No	15
Standard 2.D) Quality Improvement		
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience. (A)	No	5
2.D.2 PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress. (A)	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice. (A)	No	15
Standard 2.E) Ambulatory Sensitive Utilization[4]		
2.E.1 PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure.	No	5
2.E.2 PCPCH identifies patients with unplanned or adverse utilization patterns for at least one selected utilization measure and contacts patients, families or caregivers for follow-up care if needed, within an appropriate period of time. (A)	No	10
2.E.3 PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure. (A)	No	15
Standard 2.F) PCPCH Staff Vitality		
2.F.1 PCPCH uses a structured process to identify opportunities to improve the vitality of its staff.	No	5
2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	No	10

[4] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

COMPREHENSIVE WHOLE-PERSON CARE		
Standard 3.A) Preventative Services		
3.A.1 PCPCH routinely offers or coordinates recommended preventive services appropriate for its population (i.e. age and gender) based on best available evidence, and identifies areas for improvement. (A)	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services and has an improvement strategy in effect to address gaps in preventive service offerings as appropriate for the PCPCH patient population. (A)	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services. (A)	No	15
Standard 3.B) Medical Services		
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support. (A)	**Yes**	0
Standard 3.C) Behavioral Health Services[5]		
3.C.0 PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site, local referral resources and processes. (A)	**Yes**	0
3.C.1 PCPCH collaborates and coordinates care or is co-located with specialty mental health, substance use disorders, and developmental providers. PCPCH also provides co-management based on its patient population needs. (A)	No	5
3.C.2 PCPCH provides onsite pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals. (A)	No	10
3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers. (A)	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention		
3.D.1 PCPCH has a routine assessment to identify health-related social needs in their patient population. (A)	No	5
3.D.2 PCPCH tracks referrals to community-based agencies for patients with health-related social needs. (A)	No	10

[5] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

3.D.3 PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs. (A)	No	15
Standard 3.E) Preventative Services Reminders		
3.E.2 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders and tracks the completion of those recommended preventative services. (A)	No	10
3.E.3 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients, families, caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders and tracks the completion of those recommended preventive services. (A)	No	15
Standard 3.F) Oral Health Services		
3.F.1 PCPCH utilizes a screening and/or assessment strategy for oral health needs. (A)	No	5
3.F.2 PCPCH utilizes a screening and or/assessment strategy for oral health needs and provides age-appropriate interventions. (A)	No	10
3.F.3 PCPCH provides oral health services by dental providers. (A)	No	15
CONTINUITY		
Standard 4.A) Personal Clinician Assigned		
4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team. (D)	**Yes**	0
4.A.3 PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team. (D)	No	15
Standard 4.B) Personal Clinician Continuity		
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	**Yes**	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	No	10

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	No	15
Standard 4.C) Organization of Clinical Information		
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the Centers for Medicare and Medicaid Services and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit. (A)	**Yes**	0
Standard 4.D) Clinical Information Exchange		
4.D.2 PCPCH exchanges clinical information electronically to another provider or setting of care. (A)	No	10
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). (A)	No	15
Standard 4.E) Specialized Care Setting Transitions		
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (A)	**Yes**	0
Standard 4.F) Planning for Continuity		
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available. (A)	No	5
Standard 4.G) Medication Reconciliation		
4.G.2 PCPCH has a process for medication reconciliation for patients with complex or high-risk medication concerns. (A)	No	10
4.G.3 PCPCH provides Medication Management for patients with complex or high-risk medication concerns. (A)	No	15
COORDINATION		
Standard 5.A) Population Data Management [6]		

[6] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

5.A.1 PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its entire patient population, including the identification of sub-populations. (A)	No	5
5.A.2 PCPCH demonstrates the ability to stratify its entire patient population according to health risk such as special health care needs or health behavior. (A)	No	10
Standard 5.C) Complex Care Coordination[7]		
5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care. (A)	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs. (A)	No	10
5.C.3 PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns. (A)	No	15
Standard 5.D) Test & Result Tracking		
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely, confidential notification and explanation of results to patients, family, or caregivers as well as to ordering clinicians. (A)	No	5
Standard 5.E) Referral & Specialty Care Coordination[8]		
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians. (A)	No	5
5.E.2 A PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (e.g., hospital, SNF, long term care facility). (A)	No	10
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social service, foster care, public health, traditional health workers, behavioral health providers and organizations, and pharmacy services. (A)	No	15
Standard 5.F) End of Life Planning		

[7] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)
[8] A PCPCH can earn points for all measures in this standard if applicable (check all that apply)

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

5.F.0 PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services. (A)	**Yes**	0
5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries unless patients opt out. (A)	No	5
PATIENT AND FAMILY CENTERED CARE		
Standard 6.A) Meeting Language & Cultural Needs		
6.A.0 PCPCH offers time-of-service translation to communicate with patients, families, or caregivers in their language of choice. (A)	**Yes**	0
6.A.1 PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic. (A)	No	5
Standard 6.B) Education & Self-Management Support		
6.B.1 PCPCH provides patient-specific education resources to their patient population. (A)	No	5
6.B.2 PCPCH provides patient-specific education resources and offers self-management support resources to their patient population. (A)	No	10
6.B.3 PCPCH provides patient-specific education resources, offers self-management support resources to their patient population, and tracks utilization of multiple self-management groups. (A)	No	15
Standard 6.C) Experience of Care		
6.C.0 PCPCH surveys a sample of its population on their experience of care. The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. (A)	**Yes**	0
6.C.1 PCPCH surveys a sample of its population on their experience of care. The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. PCPCH also has a survey planning strategy in place and shares data with clinic staff.	No	5
6.C.2 PCPCH surveys a sample of its population on their experience of care using of one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es). (A)	No	10
6.C.3 PCPCH surveys a sample of its population on their experience of care using of one of the CAHPS survey tools, meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es). (A)	No	15

TABLE 1. Recognition Criteria for Patient Centered Primary Care Homes

Standard 6.D) Communication of Rights, Roles, and Responsibilities		
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship. (A)	No	5

Table 4. Required PCPCH Measures for 5 STAR designation

Practices seeking 5 STAR designation must attest to 13 of the 16 PCPCH measures listed

PCPCH Measures for 5 STAR Designation
1.A.2) In-Person Access
1.B.1) After Hours Access
1.G.2) Alternative Access
2.C.2) Patient and Family Involvement in Quality Improvement
2.D.3) Quality Improvement
2.E.2) Ambulatory Sensitive Utilization
3.C.3) Integrated Behavioral Health Services
3.D.3) Comprehensive Health Assessment & Intervention
4.B.3) Personal Clinician Continuity
4.G.3) Medication Reconciliation and Management
5.C.2) Coordination of Care
5.C.3) Individualized Care Plan
5.E.1) Referral Tracking for Specialty Care
5.E.3) Cooperation with Community Service Providers
6.A.1) Meeting Language & Cultural Needs
6.C.2 or 6. C.3) Experience of Care