Patient Centered Primary Care Home Standards
SBHC Gap Assessment Exercise

C = Contractual Attestation
D = Data Reporting Requirement
Grey Highlights = Must-Pass Measure

CORE ATTRIBUTE	STANDARD	MEASUREMENT AREA	MEASUREMENT DESCRIPTION	ASSESSMENT FINDINGS	ACTION PLAN TO FULFILL STANDARD
Access to Care	In Person Access	Appointment Access	Surveys a sample of its population on satisfaction with in-person access to care and report results **(D)**		
		After Hours Appointments	Offers access to in-person care at least 4 hours weekly outside of traditional business hours. **(C)**		
	Telephone & Electronic Access	Telephone Advice	Provides continuous access to clinical advice by telephone **(C)**		
Accountability	Performance and Clinical Quality Improvement	Performance and Clinical Quality Improvement	Tracks one quality metric from core or menu set of PCPCH Quality Measures **(C)**		
Comprehensive Whole Person Care	Scope of Services	Preventive Services	Offers a or coordinates 90% of recommended preventative services (**C)**		
		Medical Services	Reports that it routinely offers all of the following categories of services: acute care for minor illnesses, Ongoing management of chronic diseases including transitions of care; Office-based procedures, patient education and self-management. **(C)**		
		Mental Health & Substance Abuse Services	Documents its screening strategy for mental health, substance use, or developmental conditions AND document on-site and local referral resources **(C)**		

		Comprehensive Health Assessment and Intervention	Documents comprehensive health assessment and intervention for at least 3 health risk behaviors or developmental promotion behaviors. **(C)**		
Continuity	Provider Continuity	Personal Clinician Assignment	Reports the % of active patients assigned a personal clinician and/or team. **(D)**		
		Personal Clinician Continuity	Reports the % of patient visits with assigned clinician/team. **(D)**		
	Information Continuity	Organization of Clinical Information	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. **(C)**		
	Geographic Continuity	Specialized Care Settings	Has written agreement with its usual hospital providers or directly provides routine hospital care **(C)**		
Coordination & Integration	Data Management	Population Data Management	A. Demonstrates the ability to identify, aggregate, and display data regarding its patient population (C) B. Demonstrates the ability to reliably identify, track and proactively manage the care needs of a sub-population of its patients (C)		

	Care Coordination	Care Coordination	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 (C)		
		Test and Result Tracking	Demonstrates tracking of 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 (C)		
		Referral and Specialty Care Coordination	A. Demonstrates tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians (C) B. Either manages hospital or 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. (C)		
		End of Life Planning	Demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.		

Person & Family-Centered Care	Communication	Language/Cultural Interpretation	Documents the offer and/or use of either providers who speak a patient and family's language or time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice. **(C)**		
	Education & Self-Management Support	Education & Self-Management Support	Documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources (C)		
	Experience of Care	Experience of Care	Surveys a sample of its patients and families at least annually on their experience of care. They patient survey must include questions on access to care, comprehensive whole person care, continuity, coordination and integration, and person or family centered care. The recommended patient experience of care survey is one of the Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey tools (D)		