Patient-Centered Primary Care Home 2025 Recognition Criteria
Quick Reference Guide

Last Updated January 2024

This guide is intended to provide a brief overview of the Oregon Health Authority (OHA) Patient-Centered Primary Care Home (PCPCH) Program criteria for recognition that is effective January 1, 2025. The complete technical specifications for all measures will be available by March 30, 2024 at www.PrimaryCareHome.oregon.gov.

Please refer to the following definitions when using this document:

Unchanged: This measure was part of the 2020 criteria and the measure language and/or point values have not changed

Revised: This measure was part of the 2020 criteria and the measure language and/or point values have changed

New: This measure was not part of the 2020 criteria and is a new measure in the model

There are 13 must-pass measures every practice must meet to become recognized. The other measures are optional and worth 5, 10 or 15 points. A practice's overall tier of recognition is determined by the number of points they achieve by attesting to the optional measures.

2025 PCPCH Tiers		
Tier level	**Tier point range**	**Tier point distribution**
Tier 3	100- 245 points + 13 must-pass measures	145 points
Tier 4	250- 390 points + 13 must-pass measures	140 points
Tier 5	395 - 530 points + 13 must-pass measures	130 points

Important Note: Any practice applying for PCPCH recognition must review the technical specifications prior to submitting an application. The technical specifications describe each measure in more detail including what documentation the practice must have to support their attestation. Practices must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted. The technical specifications for the 2025 PCPCH recognition criteria will be available on the program website by March 30, 2024.

Practices meeting specified health equity measures can be awarded the Health Equity Designation. More information about this designation will be available by March 30, 2024.

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*				
Standard 1.A) Timely Access and Communication				
1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams.	Unchanged	No	5	No
1.A.2 PCPCH regularly tracks timely access and communication to clinical staff and care teams, and either meets specific targets or has implemented an improvement plan to improve outcomes.	Revised	No	10	No
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.	Unchanged	No	5	Yes
Standard 1.C) Telephone Access				
1.C.0 PCPCH assures that its patients have continuous access to clinical advice by telephone.	Revised	Yes	0	No
1.C.1 PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.	New	No	5	Yes
Standard 1.D) Same Day Access				
1.D.1 PCPCH offers same day appointments.	Revised	No	5	No
Standard 1.E) Electronic Access (*Check all that apply*)				
1.E.1 PCPCH regularly communicates with patients through a patient portal.	Revised	No	5	No
1.E.2 PCPCH provides patients with access to an electronic copy of their health information in an accessible format.	Revised	No	10	Yes
Standard 1.F) Prescription Refills				
1.F.2 PCPCH tracks time to completion for prescription refills.	Unchanged	No	10	No
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription refills.	Unchanged	No	15	No

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 1.G) Alternative Access *(Check all that apply)*				
1.G.1 PCPCH offers telehealth services to its patients in their primary language.	New	No	5	Yes
1.G.2 PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.	Revised	No	10	Yes
1.G.3 PCPCH regularly provides patient care in community-based settings.	New	No	15	Yes
CORE ATTRIBUTE 2: ACCOUNTABILITY - *"Take responsibility for making sure we receive the best possible health care."*				
Standard 2.A) Performance and Clinical Quality *(Check all that apply)*				
2.A.0 PCPCH tracks and reports to OHA three primary care quality measures.	Revised	Yes	0	No
2.A.1 PCPCH tracks and reports to OHA disparities in three primary care quality measures	New	No	5	No
2.A.2 PCPCH tracks, reports to OHA, and demonstrates a combination of improvement and meeting benchmarks on three primary care quality measures.	Revised	No	10	No
2.A.3 PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.	New	No	15	Yes
Standard 2.B) Value-Based Payment				
2.B.1 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with one payer.	New	No	5	No
2.B.2 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	New	No	10	No
2.B.3 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 3A or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	New	No	15	No

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
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.	Unchanged	No	5	No
2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver advisors as key members of quality, safety, program development or educational improvement activities.	Unchanged	No	10	Yes
2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	Unchanged	No	15	No
Standard 2.D) Quality Improvement				
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.	Unchanged	No	5	No
2.D.2 PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	Unchanged	No	10	No
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	Unchanged	No	15	No
Standard 2.E) Ambulatory Care Sensitive Conditions Utilization *(Check all that apply)*				
2.E.2 PCPCH identifies patients experiencing unplanned or adverse patterns in at least one utilization measure and contacts patients, families, or caregivers for follow-up care.	Revised	No	10	No
2.E.3 PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families, or caregivers for follow-up care.	New	No	15	Yes
Standard 2.F) PCPCH Staff Vitality				
2.F.1 PCPCH develops and implements a strategy to improve the vitality of its staff.	Revised	No	5	No
2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	Unchanged	No	10	No

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - *"Provide or help us get the health care, information, and services we need."*				
Standard 3.A) Preventive Services				
3.A.1 PCPCH routinely offers or coordinates recommended age and sex-specific preventive services for its patient population based on best available evidence, and identifies areas for improvement.	Revised	No	5	No
3.A.2 PCPCH routinely offers or coordinates recommended age and sex-specific preventive services and has an improvement strategy in effect to address gaps in preventive service offerings as appropriate for its patient population.	Revised	No	10	No
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and sex-specific preventive services.	Unchanged	No	15	No
Standard 3.B) Medical Services				
3.B.0 PCPCH routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.	Revised	Yes	0	No
Standard 3.C) Behavioral Health Services *(Check all that apply)*				
3.C.0 PCPCH has a routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.	Revised	Yes	0	No
3.C.2.a PCPCH collaborates or is co-located, and coordinates care, with specialty mental health, substance use disorder, and developmental providers.	Revised	No	10	No
3.C.2.b PCPCH provides pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	Revised	No	10	No
3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	Unchanged	No	15	No

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 3.D) Health-Related Social Needs (*Check all that apply*)				
3.D.2 PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.	Revised	No	10	Yes
3.D.3 PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.	Revised	No	15	Yes
Standard 3.E) Preventive Services Reminders				
3.E.1 PCPCH generates lists of patients who need reminders for preventive services and ensures that they are sent appropriate reminders.	New	No	5	No
3.E.2 PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services.	Revised	No	10	No
3.E.3 PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach strategy.	New	No	15	Yes
Standard 3.F) Oral Health Services				
3.F.1 PCPCH screens or assesses its patients for oral health needs.	Revised	No	5	No
3.F.2 PCPCH screens or assesses its patients for oral health needs and provides age-appropriate interventions.	Revised	No	10	No
3.F.3 PCPCH provides oral health services by dental providers.	Unchanged	No	15	No
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*				
Standard 4.A) Personal Clinician Assignment and Continuity				
4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team and has a process for considering patient choice in assignment. PCPCH also reports the percent of visits in which a patient saw their assigned clinician or team.	Revised	Yes	0	No

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
4.A.2 PCPCH tracks and improves the percent of visits in which a patient saw their assigned clinician or team.	Unchanged[1]	No	10	No
4.A.3 PCPCH meets a benchmark for the percent of visits in which a patient saw their assigned clinician or team.	Unchanged[2]	No	15	No
Standard 4.B) Medication Reconciliation and Management[3] (*Check all that apply*)				
4.B.2 PCPCH provides medication reconciliation for its patients.	Revised	No	10	No
4.B.3 PCPCH provides comprehensive medication management for its patients by a pharmacist.	Revised	No	15	No
Standard 4.C) Organization of Clinical Information				
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record. PCPCH updates this EHR as needed at each visit.	Revised	Yes	0	No
4.C.1 PCPCH documents their patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record.	New	No	5	No
4.C.2 PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.	New	No	10	Yes
Standard 4.D) Clinical Information Exchange				
4.D.2 PCPCH exchanges clinical information electronically with another provider or setting of care.	Revised	No	10	No
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities through an electronic health information exchange.	Revised	No	15	No

[1] This measure was 4.B.2 under the 2020 PCPCH model
[2] This measure was 4.B.3 under the 2020 PCPCH model
[3] This standard was 4.G under the 2020 PCPCH model

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 4.E) Hospital Setting Transitions				
4.E.0 PCPCH has a documented process for transitions of care with its usual hospital providers or directly provides routine hospital care.	Revised	Yes	0	No
4.E.2 PCPCH has a process for following up with its patients post-discharge from the hospital and emergency department.	New	No	10	No
Standard 4.F) Planning for Continuity				
4.F.0 PCPCH has a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available.	Revised[4]	Yes	0	No
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*				
Standard 5.A) Population Data Management				
5.A.1 PCPCH uses data on its entire patient population to track overall health needs or engage in proactive patient population management.	Revised	No	5	No
5.A.2 PCPCH stratifies its entire patient population according to health risk.	Revised	No	10	No
5.A.3 PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category.	New	No	15	Yes
Standard 5.B) Health Care Cost Navigation *(Check all that apply)*				
5.B.1 PCPCH informs its patients of preventive services that do not require cost-sharing.	New	No	5	No
5.B.3 PCPCH assists its patients in navigating the cost and payment options for their care.	New	No	15	Yes
Standard 5.C) Complex Care Coordination *(Check all that apply)*				
5.C.1 PCPCH assigns care coordination responsibilities to specific practice staff and informs patients, families, and caregivers on how to access care coordination services.	Revised	No	5	No

[4] This was made a required (must-pass) measure in the 2025 model

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
5.C.2 PCPCH identifies patients with complex care needs and coordinates their care.	Revised	No	10	No
5.C.3 PCPCH collaborates with patients, families, or caregivers to develop individualized and culturally appropriate written care plans for complex medical or social concerns.	Revised	No	15	No
Standard 5.D) Test and 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.	Unchanged	No	5	No
Standard 5.E) Referral and Care Coordination with Specialists, Care Facilities, and Governmental Systems *(Check all that apply)*				
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians.	Unchanged	No	5	No
5.E.2 PCPCH coordinates care when its patients receive care in specialized settings such as hospitals, skilled nursing or other long-term care facilities, and in-patient behavioral health facilities.	Revised	No	10	No
5.E.3 PCPCH coordinates care for its patients who are engaged with or receiving services from the Oregon Department of Human Services, criminal justice, education, or public health systems.	Revised	No	15	No
Standard 5.F) End of Life Planning				
5.F.0 PCPCH has a process for offering or coordinating hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	Revised	Yes	0	No
5.F.1 PCPCH has a process for engaging 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.	Revised	No	5	No
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - *"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."*				
Standard 6.A) Meeting Language and Health Literacy Needs (*Check all that apply*)				
6.A.0 PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their primary language.	Revised	Yes	0	No
6.A.1 PCPCH provides written patient materials in languages other than English.	Revised	No	5	Yes

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged Revised Deleted or New	Must Pass	Points Available	Health Equity Designation
6.A.2 PCPCH assures that patient communications and materials are at an appropriate health literacy level.	New	No	10	Yes
Standard 6.B) Education and Self-Management Support				
6.B.1 PCPCH provides culturally and linguistically appropriate patient-specific education resources to its patient population.	Revised	No	5	No
6.B.2 PCPCH provides culturally and linguistically appropriate patient-specific education resources and offers or connects patients, families, and caregivers with self-management support resources.	Revised	No	10	Yes
Standard 6.C) Experience of Care				
6.C.0 PCPCH surveys a sample of its population on their experiences with specific areas of care and shares results with clinic staff. PCPCH also meets a survey completion benchmark or has a strategy to increase the number of surveys completed.	Revised	Yes	0	No
6.C.1 PCPCH surveys a sample of its population on their experiences with specific areas of care and demonstrates the utilization of survey data in quality improvement activities.	Revised	No	5	No
6.C.2 PCPCH surveys a sample of its population on their experiences with specific areas of care, including health equity, and demonstrates the utilization of survey data in quality improvement activities.	Revised	No	10	Yes
Standard 6.D) Communication of Rights, Roles, and Responsibilities				
6.D.0 PCPCH has a written document or other educational materials that outlines PCPCH and patient rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.	Revised[5]	Yes	0	No
Standard 6.E) Cultural Responsiveness of Workforce				
6.E.0 PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.	New	Yes	0	No
6.E.3 PCPCH partners with one or more traditional health workers or traditional health worker services.	New	No	15	Yes

[5] This was made a required (must-pass) measure in the 2025 model