Patient-Centered Primary Care Home Program

2025 Recognition Criteria
Technical Specifications and Reporting Guide

Version 3
Effective April 2026

About the Patient-Centered Primary Care Home Program

In 2009, the Oregon Legislature created the Patient-Centered Primary Care Home (PCPCH) Program through passage of House Bill (HB) 2009 as part of a comprehensive statewide strategy for health system transformation. PCPCHs are health care clinics that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered, and equitable care. The PCPCH Program administers the application, recognition, and verification process for clinics applying to become PCPCHs. There are over 600 PCPCHs in Oregon, and more than three million people living in Oregon receive care at a PCPCH.

OHA is committed to working with community partners to eliminate health inequities by 2030. The PCPCH program contributes to this shared goal by assisting and supporting primary care clinics to build capacity to address inequities within the patient population.

Vision and mission

Vision

A sustainable, innovative, and collaborative primary care system that is foundational to better health, better care and lower costs for all Oregonians.

Mission

To be a trusted partner in primary care, collaborating with communities to set the standard for transformative, whole-person, and evidence-based care.

For more information

www.PrimaryCareHome.oregon.gov

PCPCH@oha.oregon.gov

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Patient-Centered Primary Care Home Program at pcpch@oha.oregon.gov or 971-269-7806 (voice and text). We accept all relay calls.

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Introduction

Thank you for your interest in applying for Oregon Health Authority (OHA) Patient-Centered Primary Care Home (PCPCH) recognition for your clinic. By participating in the PCPCH Program, your clinic is affirming its commitment to improving care for your patients, reducing costs in the health care system and improving the overall health of Oregonians.

The Oregon Legislature created the OHA PCPCH Program in 2009 as part of a statewide strategy for health system transformation. The PCPCH Program develops primary care delivery standards in partnership with an advisory committee, certifies clinics that meet those standards, and encourages people living in Oregon to seek care at a recognized PCPCH.

Patient-Centered Primary Care Homes are healthcare clinics that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care. At its heart, this model of care fosters strong relationships with patients and their families to better care for the whole person. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention and wellness, and managing chronic conditions.

The core attributes of Patient-Centered Primary Care Homes

Accessible: Care is available when patients need it.

Accountable: Clinics take responsibility for the population and community they serve and provide quality, evidence-based care.

Comprehensive: Patients get the care, information, and services they need to stay healthy.

Continuous: Providers know their patients and work with them to improve their health over time.

Coordinated: Care is integrated, and clinics help patients navigate the health care system to get the care they need in a safe and timely way.

Patient and Family Centered: Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

Equitable: Patients have the same access to care and the means to achieve health regardless of diverse backgrounds or circumstances. Equity is the foundation of a patient-centered primary care home.

PCPCHs impact on the "Triple Aim"

Oregon implemented the PCPCH Program as part of the state's strategy to achieve the "Triple Aim" of improving the individual's experience of care, improving population health, and decreasing the cost of care. A 2023 study on health care expenditures and utilization found that among PCPCHs, total healthcare expenditures per person were reduced by 6.3% or approximately $76 per person per quarter. It also found that every $1 increase in primary care expenditures created $12 in savings in other health care services, including emergency depart and inpatient care. This resulted in least $1.3 billion dollars in savings in the first eight years of the PCPCH program. In addition, PCPCH patients experienced lower utilization rates of inpatient services, radiology and emergency departments compared to those seeking care in non-recognized clinics. Additional program evaluation outcomes are available at the PCPCH Program Reports and Evaluations webpage at www.PrimaryCareHome.oregon.gov.

How to use this Technical Assistance (TA) Guide

The information and technical specifications in this guide are meant for clinics applying for PCPCH recognition. All clinics applying or re-applying for PCPCH recognition after January 1, 2025 must meet this recognition criteria to become a PCPCH. This guide includes descriptions of the intent of each PCPCH standard, relevant definitions, measurement criteria, and example strategies that clinics might use to meet the intent of each standard. The information provided in this guide is not intended as an all-inclusive list of the strategies clinics could employ to meet each standard.

For standards that require clinics to submit data at the time of application, this guide describes how clinics should collect, calculate, and submit this data. For standards that only require attestation at the time of application, this guide describes the information a clinic should collect and retain for documentation purposes during a verification site visit.

"Additional Tips" boxes contain helpful information and suggestions for clinics interested in exploring a particular standard in more depth. The information contained in the Additional Tips boxes are not required for PCPCH recognition or verification purposes.

"Transformation in Practice" boxes contain examples of how a clinic may have approached a specific standard or measure. Clinics are not required to use these approaches for PCPCH recognition or verification purposes but may reference these boxes for ideas.

PCPCH is a journey, not a destination

PCPCH recognition is a framework for how a clinic of any size or type can improve care for their patients. The graduated measures within each standard and the three PCPCH tier levels are designed to acknowledge the great work a clinic is already doing in a given area of care while simultaneously encouraging them to think forward about how to become better. While your

clinic may already "check the boxes" for certain PCPCH standards, you are encouraged to **truly transform the way things are done at your clinic** and implement a patient-centered approach to all activities. As described by the Primary Care Collaborative:[1]

> *"The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination. Instead, it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs."*

Clinics are also encouraged to think outside the walls of their clinic by partnering with local public health agencies and community-based organizations to educate and support patients, identify community health priorities, and develop plans to improve the overall health of their communities.

PCPCH eligibility

Any type of health care clinic that provides comprehensive primary care services is eligible to apply for PCPCH recognition. Specialty clinics may apply if they have integrated primary care providers (PCPs) and provide the full range of primary care services outlined in PCPCH Measure 3.B.0. Clinics must be able to report on 12 months of data for their quality and continuity measures, meaning that a clinic must be open for business and have access to at least 12 months of data related to primary care services prior to applying for recognition. Exceptions may be made in certain circumstances. Please contact the program for more information.

People applying for PCPCH recognition for their clinic must thoroughly review this guide, including technical specifications, prior to applying. The technical specifications describe each standard in more detail, including what documentation the clinic must be able to provide to support their attestation in the event of a verification site visit.

> ***Important Note:*** *Clinics must have all services, processes, and policies they attest to in place at the time the PCPCH application is submitted.*

If an organization operates multiple clinic sites, a separate application must be submitted for each site, with data specific to that clinic. If all clinic sites applying for recognition operate under the same policies and procedures and share the same electronic health record to document patient care, then some questions will be answered the same for each clinic site. However,

[1] Primary Care Collaborative. (2020). Defining the Medical Home: A Patient-Centered Philosophy that drives primary care excellence. *www.pcpcc.org*.

standards that require data submission must be calculated and submitted with data specific to each clinic site. If you have any questions about your clinic's eligibility, please contact us at PCPCH@oha.oregon.gov.

Standards, scoring framework, and tier levels

The PCPCH recognition criteria consist of 36 standards within six core attributes of high-quality care — accessible, accountable, comprehensive, continuous, coordinated, and patient- and family-centered. Each standard includes up to four measures that demonstrate how a clinic is implementing the standard. Thirteen of the measures are "must-pass" meaning that all clinics are required to meet them to be recognized as a PCPCH (see Table B on page 13). All other measures are optional and valued at 5, 10, or 15 points depending on their complexity and transformational value. In addition to meeting the "must pass" standards, clinics must be meeting enough optional measures to be able to attest to at least 100 points.

Each standard is classified as either a "progressive" or a "check all that apply" with regards to total points available. Within progressive standards, clinics select the measure and associated point level that best describes the level of care that they are providing (these standards offer a maximum of 15 points). Within check-all-that-apply-standards, clinics can attest to meeting multiple measures and add up their points for each one (these standards offer a maximum of 35 points).

A clinic's PCPCH tier level – Tier 3, 4 or 5 – is determined by the total point value of the measures they attested to (see Table A below). This tiered recognition structure encourages clinics to continue to improve and groups clinics that have attested to a similar number of measures into the same tier level. Tier levels are not, however, intended to be a ranking system for PCPCHs or considered a report card on a clinic's quality of care. For example, a small clinic may not have the resources to meet as many measures as a larger clinic, but may still be providing top-quality, patient-centered care within their capabilities.

Table A - Points and tiers in the 2025 PCPCH model

Tier Level	Point Range	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	135 points

Health Equity Designation

OHA is partnering with organizations across the state to work towards eliminating health inequities by 2030.[2] The PCPCH program contributes to this work by supporting and assisting primary care clinics in building their capacity to address inequities in their patient populations. Nearly all the standards and measures in the PCPCH recognition criteria include strategies to help clinics reduce disparities, improve access, and address gaps in care.

Further, clinics can be awarded a Health Equity Designation for implementing 15 or more of the 20 health-equity focused measures in the PCPCH recognition criteria (see Table C on page 15). A PCPCH at any tier level is eligible to apply for this designation. PCPCH program staff will verify that the clinic is meeting the health-equity focused measures before the designation is awarded.

Clinics must apply for the Health Equity Designation at the same time they apply or re-apply for PCPCH recognition. The PCPCH application process is described in the following section of this document. If a clinic is not meeting the Health Equity Designation requirements at the time of their PCPCH application, they can apply for the designation when they next re-apply for PCPCH recognition. Clinics can re-apply for PCPCH recognition 6 months after their most recent application if they are applying for a higher tier level or the Health Equity designation.

Application process

To apply for PCPCH recognition for your clinic, please take the following steps:

1. **Read the TA Guide** – Read this guide to develop a clear understanding of the intent behind each standard and determine if your clinic has the services, policies, and procedures in place to meet the criteria.
2. **Gather required data and documentation** – This guide includes the documentation and data that is required for each measure, either at the time of application or when your clinic is selected for a verification site visit. The PCPCH Self-Assessment Tool available on the Become Recognized as a PCPCH webpage may be helpful in gathering this data and documentation for your clinic. It can also help you estimate which tier of recognition you qualify for based on what standards you meet. **Note:** While not required at the time of attestation, we recommend gathering and saving the items listed under the sections titled "Documentation required at a Verification Site Visit" within each measure's specifications while you are going through the application process. This will reduce the administrative burden for your clinic leading up to a site visit.
3. **Submit your application** – Clinics must complete and submit their applications electronically through the online PCPCH application system. Instructions on how to set up an account and login are included on the PCPCH Program Become Recognized webpage at www.PrimaryCareHome.oregon.gov. Each clinic site must submit a separate application. After your application is submitted with all required data, OHA staff will review the application and notify you of the results in writing within 60 days.

[2] OHA's definition of health equity is included in the glossary of this guide.

What to expect after your clinic is recognized as a PCPCH

Recognition renewal requirements

Your clinic's PCPCH recognition is valid for two years, after which you will be required to re-apply to maintain your clinic's recognition. Clinics may also re-apply once every 6 months to achieve a higher tier level or the Health Equity Designation.

Payment for recognized PCPCHs

Oregon is working towards a health system that rewards high quality, efficient care that results in better health outcomes. To meet that goal, OHA is working with public and private payers across Oregon to pursue innovative payment methods that align with the PCPCH model of care. This will help primary care homes focus on what's important – health.

After your clinic is recognized as a PCPCH, there may be additional payments available from the some of the health plans that your clinic contracts with. As of January 2020, OHA requires Medicaid Coordinated Care Organizations (CCOs) to provide a per-member-per-month (PMPM) payment to PCPCHs in their network in addition to any other payments made to PCPCHs such as fee-for-service (FFS) or other Value-based Payments (VBP). These PMPM payments are meant to support a PCPCH's team-based care and care management efforts that are not reimbursed via a traditional FFS payment system such as outreach, traditional health workers, partnerships with community entities, and other non-billable types of care. **You are encouraged to contact the health plans and CCOs with which your clinic contracts to inquire about additional payments for PCPCHs.** For more information visit the PCPCH Program Aligning Payment with Quality webpage.

Verification site visits at PCPCHs

PCPCH Program staff conduct site visits at recognized PCPCHs. The purpose of site visits is to:

1. Ensure that clinics are meeting the standards and measures they attested to in their PCPCH recognition application;
2. Assess care delivery and clinic operations to ensure that the patient-centered model of care is being integrated into the care provided;
3. Collaborate to identify clinic needs, barriers to implementation, and areas of improvement so that clinics can successfully implement the PCPCH standards. The site visit team helps clinics establish improvement plans and provides technical assistance when needed.

The PCPCH Program is required by Oregon Administrative Rule to conduct a site visit to each PCPCH at least once every five years. By participating in the PCPCH program you are agreeing to a verification visit by PCPCH program staff. This TA Guide explains what documentation a clinic must provide during a verification site visit to demonstrate it is meeting the measures attested to

in its PCPCH application. The TA Guide also describes how clinics should collect and calculate any required data or documentation. Protected health information (PHI) must be removed or blocked out from any documents provided to our staff, including patient identifiers. When your clinic is chosen for a verification site visit, PCPCH program staff will contact you at least 30 days prior to the intended site visit date and work with you as your clinic prepares for the visit.

PCPCH Program Updates

Clinics are encouraged to sign up to receive the PCPCH "Program Updates" by email. This monthly e-newsletter includes important updates to the PCPCH Recognition Criteria, technical assistance, additional learning opportunities, and other resources and events relevant to primary care clinics. PCPCH Program updates and other relevant information about your clinic's recognition are communicated by email. Please ensure that the email address you provide in the online PCPCH application is up to date.

Changes at your clinic

You are required to inform the PCPCH Program of significant changes at your clinic to ensure that OHA has accurate information about clinics that are PCPCH recognized. New ownership, clinic relocation, change in clinic contact information, clinic closure, loss of key clinical staff, or other changes should be reported to PCPCH@oha.oregon.gov.

Technical assistance and resources

The PCPCH Program develops and provides technical assistance for PCPCHs at no cost to help clinics understand program requirements and implement the standards effectively. Offerings include webinars, learning collaboratives, and an online PCPCH Resource Library that includes toolkits, templates, workflow examples, self-assessment tools and more. As clinics are preparing to apply for re-apply for PCPCH recognition, PCPCH program staff are available to answer questions about the PCPCH criteria and provide guidance during the application process. During and after a site visit, PCPCH program staff also provide one-on-one coaching to clinics — identifying needs, barriers, and areas of improvement, as well as connecting them with resources to assist in their primary care transformation journey.

NCQA PCMH and Oregon PCPCH recognition

Some clinics in Oregon are recognized as a National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH). While this model is not identical to the Oregon PCPCH model, there are areas of commonality. A clinic that is NCQA PCMH certified has two options for applying PCPCH recognition:

> **Option 1:** Complete the online PCPCH application (see the Application Process section of this guide). Clinics choosing this option will be designated a tier level based on the measures attested to on the application.

Option 2: Complete an abbreviated paper PCPCH application and submit documentation of the clinic's current NCQA PCMH certification. Clinics choosing this option will be recognized as a Tier 5 PCPCH. Clinics can request an abbreviated application at PCPCH@oha.oregon.gov.

Questions?

We are here to help. Please contact the PCPCH Program team at PCPCH@oha.oregon.gov or 503-373-7768 if you have any questions about the application process or the standards for recognition.

Table B: Must-Pass measures

Clinics must meet each of these 13 measures to qualify for PCPCH recognition.

(D) *– Data submission required with application*

Standard	Must-Pass Measure
Telephone Access	**1.C.0** – PCPCH assures that its patients have continuous access to clinical advice by telephone.
Performance & Clinical Quality	**2.A.0** – PCPCH tracks and reports to OHA three primary care quality measures. **(D)**
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.
Behavioral Health Services	**3.C.0** – PCPCH has a routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.
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. **(D)**
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.
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.
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.
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.

Standard	Must-Pass Measure
Meeting Language & Health Literacy Needs	**6.A.0** – PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their primary language.
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.
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.
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.

Table C: Health Equity Designation measures

Clinics must meet 15 or more of the following 20 measures to qualify for the PCPCH Health Equity Designation.

Standard	Health Equity Designation Measures
After-Hours Access	**1.B.1** – PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
Telephone Access	**1.C.1** – PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.
Electronic Access	**1.E.2** – PCPCH provides patients with access to an electronic copy of their health information in an accessible format.
Alternative Access	**1.G.1** – PCPCH offers telehealth services to its patients in their primary language.
Alternative Access	**1.G.2** – PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.
Alternative Access	**1.G.3** – PCPCH regularly provides patient care in community-based settings.
Performance and Clinical Quality	**2.A.3** – PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.
Patient and Family Involvement in Quality Improvement	**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. ***OR*** **2.C.3** – Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.
Ambulatory Care Sensitive Conditions Utilization	**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.
Health-Related Social Needs	**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.

Standard	Health Equity Designation Measures
Health-Related Social Needs	**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.
Preventive Services Reminders	**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.
Organization of Clinical Information	**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.
Population Data Management	**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.
Health Care Cost Navigation	**5.B.3** – PCPCH assists its patients in navigating the cost and payment options for their care.
Meeting Language and Health Literacy Needs	**6.A.1** – PCPCH provides written patient materials in languages other than English.
Meeting Language and Health Literacy Needs	**6.A.2** – PCPCH assures that patient communications and materials are at an appropriate health literacy level.
Education and Self-Management Support	**6.B.2** – PCPCH provides culturally or linguistically appropriate patient-specific education resources and offers or connects patients, families, and caregivers with self-management support resources.
Experience of Care	**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.
Cultural Responsiveness of Workforce	**6.E.3** – PCPCH partners with one or more traditional health workers or traditional health worker services.

Standard 1.A – Timely Access and Communication

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 10 pts):

1.A.1	PCPCH regularly tracks timely access and communication to clinical staff and care teams.	**5 points**
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.	**10 points**

Intent of Standard 1.A

Timely access to clinical staff and care team members is a core feature of primary care. PCPCHs should have the ability to gather data to understand and reduce how long patients, families, and caregivers must wait to access primary care services and communicate with clinical staff members and care teams.

Specifications for 1.A.1

A clinic is meeting measure 1.A.1 if it is doing both of the following:

- ☑ Tracks at least one item from each of the two timely access categories in Tables 1.A: *Timely Access to Care* and *Timely Communication with Clinical Staff and Care Teams*
- ☑ Regularly shares this data with its entire staff.

Table 1.A (A): Timely access to care

"Timely Access to Care" tracking item	Scheduling target
Routine/follow-up visit or 3rd next available route/follow-up visit	10 days
Acute office visit or 3rd next available acute office visit	2 days
Urgent office visit or 3rd next available urgent office visit	1 day
Well Child Check (WCC) or 3rdnext available WCC	2 months
Annual Well Visit (AWV) or 3rd next available AWV	3 months

Table 1.A (B): Timely communication

"Timely Communication" tracking item	Target response time
Phone hold time for clinician team	20 minutes
Time to return clinical advice calls	1 day
Time to return portal messages	2 days
On-call provider: time to return call	20 minutes
Dropped calls	5%

Example:

A clinic tracks next available acute appointment type by running reports in the EHR monthly to see how quickly a patient could schedule an acute visit. It also tracks how quickly the on-call provider returns after-hours calls to patients by tracking what time the answering service notifies the on-call provider of an after-hours clinical advice call, and what time the provider calls the patient back. This information is shared with staff at the quarterly all-staff meeting or on monthly team meeting agendas.

Documentation required at a Verification Site Visit:

1. Reports or graphs showing tracking of one item from each category: Timely Access to Care and Timely Communication with Clinical Staff (e.g., EHR reports, patient portal reports, answering service data, other data tracking logs, etc.)
2. Documentation demonstrating how and when this data is shared with clinic staff, such as meeting minutes, presentations, white boards, emails, etc.

Activities that do not meet 1.A.1:

- A clinic tracks an item for Timely Access to Care but does not track an item for Timely Communication with Clinical Staff (or vise-versa).
- A clinic only shares reports or data with select staff on the quality team and not the entire staff.

Specifications for 1.A.2

A clinic is meeting measure 1.A.2 if it is doing all the following:

☑ Tracks at least one item from each of the following two timely access categories: *Timely Access to Care* and *Timely Communication with Clinical Staff and Care Teams* in Tables 1.A on page 17.

☑ Meets the scheduling target for one *Timely Access to Care* item and meets the response time target for one *Communication with Clinical Staff and Care Teams* item in Tables 1.A. A clinic has met a target if 90% or more of its scheduled appointments or response times within the last 6 or 12 months fall within the specified target.[3]

OR

Has implemented a plan to improve outcomes for one Timely Access to Care item and/or one Communication with Clinical Staff and Care Teams item.

☑ Regularly shares this data with its entire staff.

[3] PCPCHs tracking one of the "third next available" visit types must be able to provide weekly data points for the last 3 or 6 months. This data should be gathered separately for each primary care provider and averaged across all primary care providers. A clinic has met the specified target if 90% or more of those data points fall within that target (with weekends, holidays, and days off included).

Example:

Every month, the clinic generates reports of Annual Well visit openings and how quickly they are returning messages received through the patient portal. The time to respond to portal messages is already meeting the benchmark (92% of patients receive a response to a portal message within 2 business days), so the quality improvement team focuses on improving how quickly a patient can be seen for their annual wellness visit. The clinic meets to discuss scheduling, patient access trends, and strategies to decrease the time it takes for a patient to schedule their annual wellness exam with their primary care provider. This is shared with the entire staff on a regular basis and helps the clinic assess whether improved workflows increase access to patient care.

Documentation required at a Verification Site Visit:

1. Reports or graphs showing tracking of one item from each category: *Timely Access to Care* and *Timely Communication with Clinical Staff* (e.g., EHR reports, patient portal reports, answering service data, other data tracking logs, etc.)
2. Documentation demonstrating how and when this data is shared with clinic staff, such as meeting minutes, presentations, white boards, emails, etc.
3. Either one of the following:
    - Reports or graphics demonstrating that the clinic is meeting both the scheduling target for a *Timely Access to Care* item and the response time target for a *Communication with Clinical Staff and Care Teams* item.
    - A documented improvement plan or strategy for how the clinic works to improve an item from either *Timely Access to Care* or *Communication with Clinical Staff or Care Team*, such as Plan, Do, Study, Act cycles, workflow changes, meeting minutes, etc.

Activities that do not meet 1.A.2:

- A clinic runs reports on its timely access to care and timely communication with clinical staff and care teams but does not meet the benchmark on both of those categories and does not have an improvement plan for at least one.
- A clinic tracks timely access to care and timely communication with clinical staff and care teams and finds that they are already meeting the benchmark for timely access to care, but not timely communication to staff and care teams. They share this information with staff but decide not to develop an improvement plan to increase timely communication with clinical staff and care teams.
- A clinic decides to create an improvement plan for a metric they are already meeting the target for, instead of one that they are not meeting the target for.

Standard 1.B – After-Hours Access

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measure

1.B.1	PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	**5 points** ***Health Equity Measure***

Intent of Standard 1.B

Many patients, families, and caregivers are unable to easily access appointments during traditional business hours. The intent of this standard is to improve equity for patients, families, and caregivers who work or have other responsibilities during traditional business hours by ensuring that they can still access care from their primary care home for routine, urgent, and acute care. Expanded hours could potentially eliminate costly emergency department visits, while improving the continuity of care.

Relevant Definitions

Traditional business hours: These are typically defined as Monday through Friday, 8:00am to 5:00pm or 9:00am to 6:00pm, totaling 40 hours per week in which patients can have scheduled visits with their providers. Lunch or administrative hours are not considered as contributing towards the 40 hours.

Specifications for 1.B.1

A clinic is meeting measure 1.B.1 if it is consistently open for patients to have scheduled appointments with a provider(s) at least 44 hours per week not including lunch or administrative hours. The additional appointment availability must be provided onsite, accessible to the clinic's entire patient population, and include access to all the clinic's services including urgent care, acute care, routine preventive and follow-up care. Clinics are encouraged to consider their patients' unique barriers in their additional appointment availability offerings (e.g., offering both onsite or telehealth visits depending on the appointment type and individual patient preference) but must at the very least include onsite availability.

Examples:

- A clinic offers patients appointments from 8:00am – 5:00pm Monday through Friday and 9:00am – 1:00pm on Saturday.

- A clinic offers patient appointments from 7:30am – 7:00pm Monday through Friday.
- A clinic offers patient appointments from 8:00am – 5:00pm Monday through Thursday and Saturday, and on Sunday from 1:00pm – 5:00pm.

Documentation required at a Verification Site Visit:

One week's worth of scheduling template detailing routine and urgent appointments totaling at least 44 hours of appointment availability

Activities that do not meet 1.B.1:

- A clinic refers patients to an urgent care clinic or the emergency department if they need care outside of traditional business hours instead of providing additional appointment availability.
- Visits outside of traditional business hours are for urgent issues only, and do not include comprehensive care delivery, such as acute and routine care for chronic medical issues or preventive services.
- A clinic is open at least 4 hours outside traditional business hours but not open for a total of 44 hours per week. For example, the clinic is open to patients 8:00am to 6:00pm on Monday through Thursday but closes at noon on Friday.
- A clinic offers appointments to patients during the lunch hour and considers this time as after-hours access to care. Although scheduling appointments during the lunch hour is a courtesy for patients, it does not count towards the 40 hours of traditional business hours and is not considered to be outside of traditional business hours.
- A clinic only offers telehealth visits outside of traditional business hours, so patients do not have the option of an onsite visit for 44 hours each week.

Standard 1.C – Telephone Access

This is a must-pass standard. Clinics must, at a minimum, meet measure 1.C.0 to qualify for PCPCH recognition.

Measures

1.C.0	PCPCH assures that its patients have continuous access to clinical advice by telephone.	**Must Pass**
1.C.1	PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.	**5 points** ***Health Equity Measure***

Intent of Standard 1.C

Access to clinical advice outside of in-person office visits is an important function of PCPCHs and is associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that PCPCH patients, families, and caregivers can receive clinical advice via telephone from a live person at all times, ideally in their primary language and through accessible communications for individuals with disabilities.

Specifications for 1.C.0

A clinic is meeting measure 1.C.0 if it provides all its patients access to a live person via telephone for clinical advice 24 hours a day, 7 days per week. Additionally, the clinic must have documented policies and procedures to ensure that all after-hours telephone encounters are documented in the EHR within 24 hours of the call. It is not required that the provider receiving the call or giving clinical advice has real-time access to the patient's medical record, although this is ideal.

Examples:

- A live person at the clinic answers business and after-hours phone calls and refers patients to a nurse or clinician for clinical advice, as appropriate.
- An on-call provider or nurse answers business and after-hours phone calls and records the encounter in the phone notes.
- The clinic has a live answering service that triages appropriate business and after-hours phone calls to an on-call clinician.
- The clinic contracts with a 24/7 nurse advice line. The nurse advice line sends faxes to the clinic with information about patient calls that came in the night before and inputs this information into patients' medical records.

Activities that do not meet 1.C.0:

- The clinic routinely uses a voicemail service to answer phone calls during or after business hours, with no option for patients to access clinical advice from a live person.
- The clinic uses an automated message that refers patients to the emergency room or an urgent care clinic during or after business hours.
- The clinic uses non-clinical staff (e.g., receptionist) to address medical concerns via phone instead of having real-time access to a clinician.
- The clinic initiates after-hours calls to patients with lab results, test results, or refill notifications. The communication is not initiated by the patient.

Transformation in Practice

Accessing Clinical Advice by Telephone in Rural Communities

A small rural clinic has developed an innovative way to ensure patients have 24/7 access to clinical advice. It organized an on-call pool of providers from other clinics in the county, and they all share call rotation. The providers do not have a common EHR so instead use a paper-based process to document their after-hours calls. Providers fax or scan/email individual clinics their after-hours notes within 24 hours of the call.

Specifications for 1.C.1

A clinic is meeting measure 1.C.1 if it is meeting all the specifications for 1.C.0 and ensures that its patients receive these services in their primary language.

Examples:

- A clinic uses its EHR to run a report of all the languages other than English spoken by its patients. It contacts the answering service it contracts with to verify that interpreters are available in those language after hours. The clinic has a written workflow that the answering service will contact a provider with the patient and the interpreter already on the line. The provider documents the encounter in the patients chart the next morning when in clinic.
- A clinic does not have an answering service, and patients speak directly with an on-call provider after hours. After assessing their language needs, the clinic works with its interpreter service provider to ensure that it will have afterhours access to interpreter services for its patients with primary languages other than English. The clinic has a workflow for on-call providers and has created a “cheat sheet” for them to use at home to make the process more manageable.

Documentation required during a Health Equity Designation review:

Documentation that after-hours clinical advice is available to patients in their primary language. Examples:

- Evidence that the after-hours service, 24/7 nurse advice line or other service provider that the clinic contracts with includes interpretation services if requested by the patient
- A policy, procedure, or workflow that shows how the provider is accessing interpretive services after hours and documenting this in the medical record
- Evidence that an interpreter was utilized during an after-hours clinic advice call between a provider and a patient, family member, or caregiver in response to a call that was initiated by the patient

Activities that do not meet 1.C.1:

- A clinic provides its patients access to a live person via telephone for clinical advice 24 hours a day, 7 days per week in English only.
- A clinic has bilingual providers but cannot demonstrate how it would accommodate patients with primary languages not spoken by its bilingual providers.

Standard 1.D – Same-Day Access

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measure

1.D.1	PCPCH offers same-day appointments.	**5 points**

Intent of Standard 1.D

Not all patient needs can be scheduled in advance. To provide the best care for patients and prevent excess utilization of emergency services, patients should have access to their primary care home for urgent needs that can be addressed in an ambulatory setting. Same-day access is important for achieving decreased wait times, decreased visit backlogs, decreased no-show rates, and increased patient satisfaction.

Specifications for 1.D.1

A clinic is meeting measure 1.D.1 if it reserves some appointments for patients that call that day with urgent needs or allows for specific times of the day when walk-in appointments are available. Ideally, all providers should have same-day availability. The same-day appointments must be co-located at the clinic. Services are co-located when they share the same physical location and involve access to the medical record. Services are not co-located if a patient needs to travel to separate locations to access them.

Examples:

- A clinic has a written policy that includes directions for phone staff to ask patients if they need a same day appointment, and a process to schedule these appointments as requested.
- A clinic ensures each provider in the clinic has two AM and two PM templated “Same Day” appointment types every day that they are in clinic.

Activities that do not meet 1.D.1:

- The first appointment window of the day is always overbooked.
- Patients calling with urgent needs are not scheduled on the same day of request, but a message is delivered to their primary care provider for consideration of an overbook.
- Only one provider has same day appointments templated into their schedule and these appointment slots are only available to their own patient panel.
- Same day appointments are only made available to patients with certain medical needs, rather than being available to the clinic’s entire patient population.

Standard 1.E – Electronic Access

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 15 pts):

1.E.1	PCPCH regularly communicates with patients through a patient portal.	**5 points**
1.E.2	PCPCH provides patients with access to an electronic copy of their health information in an accessible format.	**10 points** ***Health Equity Measure***

Intent of Standard 1.E

When surveyed, patients indicate that electronic access to their health information and electronic communication is highly desirable.[4] A primary care home striving to provide access in the form patients prefer should facilitate communication through a patient portal and provide access to health information electronically, in an accessible format.

Relevant Definitions

Download: The movement of information from online to physical electronic media.

Patient portal message: Service provided by a physician or other qualified health professional to a patient using a web-based communication network for a single patient encounter. The standard patient portal message typically involves a patient submitting a medical concern and the provider securely relaying medical advice or care.

Transmit: This may be any means of electronic transmission according to any transport standard(s) (e.g., SMTP, FTP, REST, SOAP). The relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

[4] Hassol, A. (2004). Patient experiences and attitudes about access to patient electronic health care record and linked web messaging. *Journal of the American Medical Informatics Association*, 11(6), 505-513.

Specifications for 1.E.1

A clinic is meeting measure 1.E.1 if it regularly communicates with patients through a patient portal and ensures that both patients and staff understand how this tool should be used. The clinic must have a protocol with defined expectations for portal message response times, how patients can utilize the portal, what type of care they can expect to receive through the portal, and standards for acute needs, non-urgent needs, and chronic care management. The clinic must share this information with patients and staff. Ideally, clinics will take steps to ensure that portal communications accommodate those with disabilities or with primary languages other than English.

Example:

A clinic has a protocol that describes what types of communications and services its patients can access though the portal. It sets standards for a two-hour response time to incoming patient portal messages and establishes that this method it is not to be used in emergencies, sharing this information with patients on a flyer, in the new patient packet, and with new staff during onboarding. Once a patient has submitted a medical concern, the appropriate staff respond in a timely manner.

Activities that do not meet 1.E.1:

- Sending lab results though the portal without two-way communication or medical advice regarding the lab results.
- Sending prescription refill notifications to patients
- Any one-sided notification to a patient population such as After Visit Summary (AVS), flu shot clinic, preventive service or lab reminder, etc.

Specifications for 1.E.2

A clinic is meeting measure 1.E.2 if its patients can view, download, and transmit their health information online in a timely manner and in an accessible format. Services might include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, or instructions on how to create a login. The clinic also offers any other instructions, tools, or materials that patients may need to view, download, or transmit their health information.

Health information includes lab test results, problem lists, medication lists, and medication allergy lists. The clinic ensures that health information is up to date in the clinic's certified electronic health record technology (CEHRT) and accessible to the patient (or patient-authorized representative). Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity protected.

Clinics must ensure that electronic health information is available in languages other than English and have alternate formats accessible for patients with disabilities. For example, many patient portal interfaces have multilingual functionalities that make them accessible in Spanish and other languages or have features such as large print and contrasted color for visual

impairment. Clinics with electronic platforms that have limited real-time translation or formatting capabilities could meet this measure by demonstrating a process by which electronic health information or portal communications can be translated, interpreted, or read to the patient on request. Clinics must demonstrate how their patients are made aware of the accessibility options available to them.

Examples:

- A clinic uses the portal features in their EHR for patients, authorized family members, and caregivers to view records and lab results, ask questions, and request appointments or prescription refills. The EHR is enabled with a feature where this information can be translated into languages other than English on demand by the patient, which patients are made aware of in their welcome packet and in the portal itself. Daily, the clinic responds to requests from patients, families, and caregivers to view items that are not displayed within their patient portal.
- A clinic has a written protocol for how to ensure that its patients can access their health information in an accessible format online. In every new patient packet the clinic includes a document explaining how patients who need to access their health information in an accessible format can contact the community health worker or patient navigator at the clinic. When contacted by a patient, the community health worker or patient navigator assists the patient in accessing their health information online using relevant tools and resources such as connecting the patient with an interpreter, reading the health information to the patient directly, or ensuring the patient has access to screen-reading software.

Additional Tip

Clinics are encouraged to translate this portal communication document into the most common languages other than English spoken by patients of the clinic.

Documentation required at a Verification Site Visit:

Documentation that demonstrates how patients can view, download, and transmit their health information from the patient portal in a timely manner and in an accessible format for patients with disabilities and primary languages other than English. Examples might include:

- A screen shot or other documentation demonstrating that a clinic's patient portal is compatible with screen-reading software that enables a blind or visually impaired user to read the text that is displayed on the computer screen with a speech synthesizer or braille display.
- A screen shot or other documentation showing a clinic's patient portal can translate health information into languages other than English.
- A policy, protocol or workflow describing how patients whose primary language is not English or patients who have a disability can access their health information online and how the clinic communicates these options to its patients.

Activities that do not meet 1.E.2:

- Electronic newsletters about the clinic
- A website without secure access to protected patient information
- Electronic reminders about patient appointments
- Electronic billing systems
- A clinic offers secure electronic access to health information but only in English and has no accommodations available to those with a disability or whose primary language is not English.

Additional Resources:

- 711 for Telecommunications Relay Service (Federal Communications Commission)
- Multilingual Patient Engagement Resources (Health Information Technology, Evaluation, and Quality Center)

Standard 1.F – Prescription Refills

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

1.F.2	PCPCH tracks time to completion for prescription refills.	**10 points**
1.F.3	PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription refills.	**15 points**

Intent of Standard 1.F

Timely prescription refills help patients avoid barriers or gaps in appropriate treatment and have been identified as crucial for controlling chronic conditions.[5] Since this is a complex problem, measuring timely refills helps quantify current practices and establish a standard of care.

Specifications for 1.F.2

A clinic is meeting measure 1.F.2 if it regularly tracks how long it takes to complete patient/pharmacy requests for medication refills. A refill is considered complete when it has been approved by the provider, or it has been ordered electronically. If the refill request is not approved, but canceled or denied, it can be considered complete. Clinics typically utilize an EHR system to calculate the time between receiving the initial request for a medication refill from the patient/pharmacy and sending the authorized refill back to the pharmacy or printing the prescription for the patient. A chart audit of at least 30 patient records can be used in cases where EHR tracking is unavailable, if the chart audit is performed on a regular basis (i.e., more than once per year).

Examples:

- Quarterly, the clinic utilizes an EHR system to calculate the time between receiving the initial request for a medication refill from the patient/pharmacy and sending the authorized refill back to the pharmacy or printing the prescription for the patient.
- Monthly, the clinic conducts a chart audit of at least 30 patient records to determine refill completion times.

[5] Odegard, P. S. & Gray, S. L. (2008). Barriers to medication adherence in poorly controlled diabetes mellitus. *The Diabetes Educator*, 34(4), 692-697.

Documentation required at a Verification Site Visit:

A log that tracks times for refill completion, the results of a chart review, or an electronic medical record report that includes tracking time to refill completion

Activities that do not meet 1.F.2:

The clinic generates a report on refill completion times only once per year rather than tracking it on a more regular basis.

Specifications for 1.F.3

A clinic is meeting measure 1.F.3 if it is doing both of the following:

- ☑ Tracks how long it takes to complete patient/pharmacy requests for medication refills. A refill is considered complete when it has been approved by the provider, or it has been ordered electronically. If the refill request is not approved, but canceled or denied, it can be considered complete. Clinics typically utilize an EHR system to calculate the time between receiving the initial request for a medication refill from the patient/pharmacy and sending the authorized refill back to the pharmacy or printing the prescription for the patient. A chart audit of at least 30 patient records can be used in cases where EHR tracking is unavailable, if the chart audit is performed on a regular basis (i.e., more than once per year).
- ☑ Either meeting the benchmark or demonstrating improvement on prescription turnaround time.

Benchmark: 90% of prescription refills are completed within 48 hours over the last 12 months.

Improvement: Demonstrate either one of the following:

- ≥ 10 percentage point improvement over 12 months in the number of prescriptions refilled within 48 hours.
- ≥ 5 percentage point improvement over 6 months in the number of prescriptions refilled within 48 hours.

The 48-hour timeframe includes business days only. If a refill request is received by the care team on a Friday, then Saturday and Sunday are not included in the 48-hour count unless the clinic operates with full staff on weekends.

Examples:

- The clinic has completed 90% of prescription refills within 48 hours over the last 12 months.
- The clinic has increased the percentage of prescription refills completed within 48 hours from 60% to 70% over the last 12 months.
- The clinic has increased the percentage of prescription refills completed within 48 hours from 60% to 65% over the last 6 months.

Documentation required at a Verification Site Visit:

A log that tracks times to refill completion, the results of a chart review, or an electronic medical record report that includes tracked time to refill completion and demonstrates meeting the benchmark or showing improvement. *Note: multiple reports are required in order to demonstrate improvement over time to completion for prescription refills*

Activities that do not meet 1.F.3:

The clinic is tracking prescription refill completion times but is not meeting the 90% benchmark or haven't demonstrated minimum improvement over the last 6 or 12 months.

Transformation in Practice

A clinic decides to explore their prescription refill turnaround data to see if they can identify any gaps among various patient subgroups. They discover that their rural patients are experiencing longer wait times for prescription refills. To improve turnaround time, they develop a process whereby patients can request refills via their patient portal, as well as a telehealth appointment scheduling process for medications that require an additional appointment to refill, so that patients don't have to travel to the clinic to receive approval. These changes help the clinic to meet the refill turnaround time benchmark.

Standard 1.G – Alternative Access

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 30 pts):

1.G.1	PCPCH offers telehealth services to its patients in their primary language.	**5 points** ***Health Equity Measure***
1.G.2	PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.	**10 points** ***Health Equity Measure***
1.G.3	PCPCH regularly provides patient care in community-based settings.	**15 points** ***Health Equity Measure***

Intent of Standard 1.G

All patients should have the same opportunity to access their provider or care team. Some patients face barriers with traditional office visits. Clinics that offer telehealth or alternative visit types are extending services to patients that may not receive care if only given the option of a traditional office visit. Clinics can also improve access to care for their wider community by offering primary care services in a local community setting.

Relevant Definitions

***Medical decision-making*:** A physician, or other licensed provider who has medical decision-making authority applying accumulated knowledge to a specific subset of patient information to produce a decision that may be a diagnosis, prognosis, course of therapy, or the selection of further tests. Medical decision making is typically in scope for the following providers: Physician (MD, DO, ND), Physician Assistant, Nurse Practitioner (NP, PMHNP), Dentist (DMD, DDS), and to a more limited extent a Nurse (RN).

***Qualified health care professional*:** For the purposes of 1.G, this refers to a physician (MD, DO, ND), Physician Assistant, Nurse or Nurse Practitioner (FNP, RN), Behavioral Health Provider (PhD, PsyD, LCSW, LPC, LMFT,), Care Coordinator, Pharmacist, Traditional Health Worker, Registered Dietitian or Nutritionist.

Traditional in-office visit: A one-on-one encounter between a patient and a provider that takes place at the clinic address, that results in an evaluation and management of services provided to the patient.

Specifications for 1.G.1

A clinic is meeting measure 1.G.1 if it offers its patients telehealth visits as an alternative to traditional in-office visits. Telehealth visits must be offered to patients in their preferred location, include at least 10-15 minutes of medical decision-making, and adhere to the following criteria:

1. The patient agrees to telehealth service terms, privacy policy, and charge for receiving a telehealth visit from a physician or other licensed provider.
2. Communication occurs over a HIPAA-compliant online connection.
3. The treating provider appropriately documents the telehealth visit, including all pertinent communication related to the encounter, in the patient's medical/health record.
4. If not the patient's primary care physician (PCP), the treating provider documents in the same electronic health record or forwards a summary of the telehealth visit to the patient's PCP, and communicates with the PCP as necessary.

Additionally, the clinic must make interpreter services available during telehealth appointments to patients with primary languages other than English. Interpretation services do not need to include video to meet this measure, but must at a minimum include some form of audio interpretation.

Examples:

- A clinic has a patient population that sometimes experiences barriers in making it to the clinic location (e.g., travel expenses, caretaking responsibilities, incompatible working hours, etc.). To improve access to their services, the clinic offers telehealth appointments for conditions that can be performed virtually without a reduction in quality of care. The clinic makes its patients aware of this option via their scheduling team and offers interpretation services during these visits to patients with primary languages other than English.
- A clinic is located in a rural area and has patients that often need to travel 30 minutes or more to reach the clinic address. They offer their patients telehealth appointments at their location of choice. Though they don't have many patients with primary languages other than English, they still ensure that the telehealth technologies they contract with include interpretive services and that staff know how to use them should the need arise.

Documentation required during a Health Equity Designation review:

Chart notes from a telehealth appointment (with patient information redacted)

Activities that do not meet 1.G.1:

- A clinic uses telehealth technologies to connect patients with providers or specialists, but patients need to travel to the clinic to receive these services.

- A clinic offers telehealth visits but is not prepared to provide interpreter services during these visits should the need arise.
- A clinic's care coordinators care plan with patients by phone (not all health care professionals are qualified to engage in medical decision-making).

Specifications for 1.G.2

A clinic is meeting measure 1.G.2 if it regularly delivers care to its established patients in at least one way that is an alternative to traditional in-office visits and improves access to care. Alternative visits (see options below) must contain medical decision-making and be relevant to the unique needs of the clinic's patient population. They must also be offered on an ongoing basis, though the exact frequency can vary based on the type and patient need. A clinic can leverage organization-wide resources to meet this measure so long as clinic staff are directly involved in the delivery of care.

Alternative visit types relevant to 1.G.2:

Alternative locations: Visits at an alternative location such as patients' home or current place of residence, skilled nursing facility, independent care facility, rehabilitation center, senior home, or other community setting. Care can be provided at these alternative locations from mobile vans or directly onsite but must include medical decision-making.

Group visits or patient education classes with individual assessment and services: Visits that involve multiple patients at once. These visits can sometimes take the form of a workshop or class that is facilitated by a provider or qualified health care professional. Group visits can be either onsite, virtual, or in a community setting but must include individual patient assessment and medical decision-making to qualify as an alternative visit type.

Important Note: Not all qualified health care professionals can provide medical decision-making, meaning that an additional provider may need to be present at the class/workshop if this is out of scope for the facilitator. Classes or workshops that do not involve medical decision-making would be considered self-management support (see Standard 6.B) rather than an alternative visit type.

Examples:

- A clinic offers its patients mobile van visits offsite every other Monday. These mobile appointment slots are typically filled, and patient feedback suggests that they are improving care for elderly patients, those with disabilities, and those located farther from the clinic address.
- A clinic starts a diabetes education group class for its patients once per month, in the evening, that is facilitated by a Nutritionist. Following the class, a physician offers one-on-one medical decision-making for each group participant. Survey results indicate that these classes are improving access to care for these patients.

- After receiving feedback from a patient-family advisory council, a clinic finds that home or SNF visits best meet the needs of their patient population. They have two providers that offer in-home or SNF visits on a regular basis. Appointments are listed as such on the schedule or in the chart; "Alternative Visit Type", or "Home/SNF visit."

Documentation required at a Verification Site Visit:

Examples of chart notes from alternative visits

Activities that do not meet 1.G.2:

- A clinic is offering alternative visit types but cannot demonstrate that they are being utilized on a regular basis or improving access to care for its specific patient population.
- A clinic refers patients to external specialists that offers alternative visits, but the clinics' own staff are not involved in delivering care.
- A clinic offers classes or workshops that are not facilitated by a physician or other qualified health care professional and do not involve any individual patient medical decision-making.
- A provider of a clinic acts as the medical director or employee at another site of care (e.g., Skilled Nursing Facility), but does not see the clinic's assigned primary care patients at this facility.

Specifications for 1.G.3

A clinic is meeting measure 1.G.3 if it provides health care services to residents in an external community setting, regardless of their patient status. Community settings may include schools, libraries, clubs, shelters, fire departments, agricultural work sites, communal events, or other settings that local community residents frequent. Health care services can include screenings, preventive services, tests, treatments, or other forms of medical care. Clinics may choose to provide care at community settings from mobile vans or directly onsite. The clinic can partner with external entities and larger organizations to meet this measure, so long as clinic staff are among those providing care.

Examples:

- A clinic partners with a community-based organization (CBO) to provide select screenings out of a mobile van at agricultural work sites and migrant camps once a quarter.
- Each year, a clinic hosts a back-to-school health fair for students at their local k-12 schools during which clinic staff provide well-child checks, sports physicals, and immunizations for students on a first-come, first-serve basis. The clinic charges a flat $10 fee for students that are not registered patients to cover event costs while ensuring that the services are still financially accessible to the average family.
- A clinic sets up a quarterly community outreach booth at various community events in which staff provide reproductive health counseling, oral birth control prescriptions,

condoms, and rapid STI testing. Staff assist interested non-patients in filling out registration paperwork with the clinic.

Documentation required at a Verification Site Visit:

A description of the community-based care events including the community location(s), types of services offered, the clinic staff involved, and how often they occur

Activities that do not meet 1.G.3:

- A clinic offers care in an alternative community setting but only to its registered patients.
- A clinic offers patient education, self-management resources, social services, or health insurance navigation at an external community setting but this does not involve any preventative screenings or medical services.
- A clinic has offered care at a community setting in the past as part of a special event but has no plans or timeline for when the next event will occur.
- A clinic hosts a vaccine event in the community that includes only vaccines that are easily accessed in other community settings (i.e., pharmacies, workplaces, public health departments, etc.). For example, a clinic is only offering “flu shots” in the community.

Standard 2.A – Performance and Clinical Quality

This is a must-pass standard. Clinics must, at a minimum, meet measure 2.A.0 to qualify for PCPCH recognition.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 30 pts):

2.A.0	PCPCH tracks and reports to OHA three primary care quality measures.	**Must Pass**
2.A.1	PCPCH tracks and reports to OHA disparities in three primary care quality measures.	**5 points**
2.A.2	PCPCH tracks, reports to OHA, and demonstrates a combination of improvement and meeting benchmarks on three primary care quality measures.	**10 points**
2.A.3	PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.	**15 points** ***Health Equity Measure***

Intent of Standard 2.A

Measuring and improving on the quality of clinical primary care services is a foundational aim for PCPCHs. The intent of this standard is to ensure that PCPCHs are monitoring clinical quality data and using this data to improve their performance where appropriate. In addition, this standard encourages clinics to identify patient subgroups that are experiencing disparities in access or utilization of primary care services and to work towards closing these gaps where possible. It is important that clinics monitor clinical quality measures and disparities that are meaningful to their patient population as a whole.

Note: Clinics attesting to multiple measures in Standard 2.A are expected to use the same three Primary Care Quality Measures for each one.

Relevant Definitions

Health disparities: Differences in the presence of disease, health outcomes, or access to health care services between various populations that are not due to differences in health care needs or patient preferences. In the context of PCPCH Standard 2.A, health disparities refer to a difference in a PCPCH's performance on a primary care quality measure between one or more patient subgroups and its general patient population.

Primary Care Quality Measures: Metrics that reflect the quality of a patient population's overall health and wellbeing. These metrics typically center on access to primary care services, clinical outcomes, coordination of care and community services, health behaviors, preventive care and screening, or utilization of health services. While there sometimes exists some overlap between "primary care quality measures" and the "ambulatory care sensitive conditions utilization measures" referenced in PCPCH Standard 2.E, clinics attesting to both of these standards must select different measures for each.

Qualifying quality measures lists: The lists of primary care quality measures provided by select measure stewards that PCPCHs may choose from to meet PCPCH Standard 2.A. The qualifying quality measure lists are included on page 39. Clinics are encouraged to select measures that they are already tracking and reporting on for other similar health authorities.

Specifications for 2.A.0

A clinic is meeting measure 2.A.0 if it tracks at least three primary care quality measures from one or more of the qualifying lists below, and reports its current performance (numerator and denominator) on these measures to the OHA via the PCPCH online application. The quality measures selected must reflect the various types of patients served by the clinic. For example, a family practice clinic should monitor both adult and pediatric quality measures. In addition, the data collected to calculate performance on these measures must be aggregated across all relevant providers and patients in the clinic. For example, if a clinic selects a quality measure from a CCO Performance Metric list, they must track data for all applicable patients at the clinic, not just Oregon Health Plan members.

Qualifying Quality Measures Lists:

- CCO Performance Metrics (CCO Incentive Measures & State Quality Measures)
- CMS Core Set of Adult Health Care Quality Measures
- CMS Core Set of Children's Health Care Quality Measures
- Core Quality Measures Collaborative (CQMC) Core Quality Measure Sets
- FQHC Uniform Data System Quality of Care Measures
- Health Plan Quality Metrics (HPQM) List (See "*Aligned Measures Menu*")
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Merit-based Incentive Payment System (MIPS) Measures

Calculating Current Performance: To calculate their numerator and denominator for their selected quality measures, clinics should use the specifications/instructions provided by the health authorities listed under the "Qualifying Quality Measures Lists" section above. Clinics are responsible for ensuring that they are using the most up-to-date specifications available for their selected measures.

Accepted Data Collection Methods:

- Querying an electronic medical record system

- Manual chart audit (chart review) with at least 30 patient charts[6]
- Quality measures produced from claims data by a 3rd party such as an Independent Practice Association (IPA) or health plan[7]

Data Sample Size & Measurement Period: For each quality measure, clinics using a query or 3rd party claims data must include in the sample all relevant data from last 6 or 12 months, with at least 30 patients included in the denominator. Samples drawn via manual chart audits must include at least 30 patient charts randomly drawn from all relevant patient charts in the last 6 or 12 months.

Clinics only attesting to 2.A.0 are advised to include data from the last 12 months instead of the last 6 months for each quality measure. Clinics attesting to multiple measures in this standard must use the same three Primary Care Quality Measures for each one and ensure that the measurement period used to calculate current performance for 2.A.0 (either 6 or 12 months) matches that used to calculate current performance for 2.A.1, 2.A.2, or 2.A.3.

Documentation required at a Verification Site Visit:

1. Copy of the specifications used for each of the three quality measures, including the name of qualifying source or measure steward (please note that the three quality measures demonstrated during a site visit must match those selected in the online application)
2. The data used to calculate the clinic's current performance (numerator, denominator, and resulting percentage) for the three selected quality measures

Activities that do not meet 2.A.0

- A clinic only uses data from the last month to calculate its current performance on its selected quality measures. Clinics must include data from the last 6 months or 12 months.
- A clinic tracks quality measures, but only includes patients with a specific payer (e.g., Oregon Health Plan members, Medicare members, etc.) in their numerator and denominator.

Specifications for 2.A.1

A clinic is meeting 2.A.1 if it is meeting the specifications for 2.A.0 and can identify one or more patient subgroups that are experiencing health disparities in the clinic's three primary care

[6] For more information about setting up an internal audit for practice improvement, self-assessment or submitting data for your quality measures, please see the AAFP American Academy of Family Physicians resource: Eight Steps to a Chart Audit for Quality.

[7] Clinics submitting quality measures generated by a 3rd party from claims data must review this data prior to PCPCH application submission. The methodology used to develop external reports should be transparent and verifiable.

quality measures. Patient subgroups may be defined by characteristics such as race, ethnicity, language, disability status, gender, gender identity, sexual orientation, age, special or complex health needs, social class, geographic region, life circumstances, health-related social needs, or other characteristics relevant to the clinic's patient population.[8]

Examples:

- A clinic is tracking three primary care quality measures: "Diabetes: Hba1c poor control," "Colorectal cancer screening," and "Cervical Cancer Screening." The clinic can segment its performance data on each of these measures by race. In doing so, the clinic identifies one racial subgroup of patients that are being screened less for colorectal and cervical cancer than their average patient, and another racial subgroup that is experiencing higher (HbA1c) levels than their average patient with diabetes.
- A clinic is tracking three primary care quality measures and is able to pull out and review its current performance data for rural patients specifically. In doing so, the clinic identifies that its rural patients are experiencing worse outcomes among these measures than non-rural patients.
- A pediatric clinic is tracking three primary care quality measures. After analyzing the data, the clinic discovers that certain subsets of its Children and Youth with Special Health Care Needs (CYSHCN) are experiencing worse outcomes among these primary care quality measures when compared to the rest of its patient population. For example, it finds that its performance on "Preventive dental or oral services" is lower among children and youth with autism spectrum disorder.

Documentation required at a Verification Site Visit:

1. Copy of the specifications used for each of the three quality measures, including the name of qualifying source or measure steward (please note that the three quality measures demonstrated during a site visit must match those selected in the online application)
2. The data used to calculate the clinic's current performance for the three selected quality measures, including a breakdown or summary of the disparities experienced by one or more patient subgroups

Activities that do not meet 2.A.1:

- A clinic is not able to segment its quality measure performance data or isolate the data for a patient subgroup.
- A clinic can analyze its performance data in this way, but has not identified a patient subgroup experiencing disparities.

Additional Resources:

Stratifying HEDIS Quality Measures (Race & Ethnicity Stratification Learning Network)

[8] See *PCPCH Standard 4.C – Organization of Clinical Information* for guidance around collecting demographic data from patients in a trauma-informed and trust-building way.

Specifications for 2.A.2

A clinic is meeting measure 2.A.2 if it is doing all of the following:

- ☑ Is meeting the specifications for 2.A.0.
- ☑ Has improved on at least one of its three selected quality measures (for which it is not yet meeting the benchmark at its baseline) in the last 6 or 12 months and has demonstrated this in the PCPCH online application by providing its baseline, improvement target, and current performance.
- ☑ Either meets a benchmark or can demonstrate improvement on the other two quality measures.

Note: When demonstrating improvement, the measurement period chosen to calculate the clinic's current performance must match that chosen for 2.A.0 (either 6 or 12 months). This means that, in the PCPCH online application system, the current performance reported under 2.A.2 for a given quality measure must match the current performance reported under 2.A.0 for the same quality measure. Because the current performance will be compared to a baseline, the total data measurement period will include either the past 24 months of data (year-by-year comparison) or the past 12 months of data (6-by-6-month comparison).

Identifying Benchmarks: For each of their three selected primary care quality measures, a clinic should refer to the benchmark provided by the qualifying measure steward (see page 39 for approved list). If a benchmark is not available through the original measure steward, then clinics should select a benchmark from the following sources in order:

1. CCO Performance Metrics (CCO Incentive Measures & State Quality Measures)
2. A benchmark provided by a relevant health authority (e.g., "Healthy People 2030")

If not using the original measure steward benchmark or a CCO benchmark, clinics must be able to demonstrate why the benchmark they chose makes sense for their patient population and meets the intent of this standard. To reduce administrative burden, it is highly recommended that clinics choose quality measures with benchmarks that they are already reporting on for other similar health authorities or programs.

Demonstrating Improvement:

What constitutes as "improvement" for a clinic will depend on its baseline performance and an improvement target that is unique to the clinic. Clinics must calculate their baseline, improvement target, and current performance using the steps below.

> **Step 1*: Identify the specifications and benchmarks for your selected quality measure.*** Clinics should use the specifications/instructions provided by the health authorities listed under the "Qualifying Quality Measures Lists" section on page 39. See section above for guidance around identifying a benchmark.
>
> **Step 2*: Calculate your baseline percentage.*** The data used for this calculation will be from the 6 or 12 months directly preceding the measurement period used for your current

performance. For example, if Lady Bug Clinic was attesting in January of 2024 and calculated their current performance using data from the last year (January – December 2023) then they would use data from the year before (January – December 2022) to calculate their baseline performance. But if they calculated their current performance using data from the last 6 months (July – December 2023), then they would use data from the 6 months before (January – June 2023) to calculate their baseline. The measurement period used for your baseline (whether it be 6 or 12 months) must align with the measurement period used for 2.A.0. Please note that if your baseline percentage is already meeting the benchmark, then you cannot use that quality measure to demonstrate improvement.

Step 3: ***Calculate your unique improvement target*** using the formulas below.

First calculate "X" using the formula below:

$$\frac{\text{[quality measure benchmark]} - \text{[clinic baseline performance]}}{10} = \mathbf{X}$$

Then calculate your unique improvement target using the formula below:

[clinic baseline performance] + [x] = **Improvement Target**

For example, suppose Lady Bug Clinic is tracking "Oral Evaluation for Adults with Diabetes" using the CCO Metrics specifications. They calculate their baseline performance on this measure as 22% and see that the current CCO benchmark is 31%. They would calculate their improvement target as:

$$\frac{31 - 22}{10} = 0.9$$

$$22 + 0.9 = \mathbf{22.9\%}$$

Step 4: Compare improvement target to your current performance. If your clinic's current performance meets or surpasses your clinic's improvement target, you have successfully demonstrated improvement in this quality measure. See instructions on pages 39-40 for calculating your clinic's current performance. Note that the measurement period (i.e., either the most recent 6 or 12 months) must be equal to the measurement period used for your baseline. For example, if you used 12 months of data from 2022 to calculate your baseline, you must use 12 months of data from 2023 to calculate your current performance.

Documentation required at a Verification Site Visit:

1. Copy of the specifications used for each of the three quality measures, including the name of qualifying source or measure steward (please note that the three quality

measures demonstrated during a site visit must match those selected in the online application)

2. *If not included with the specifications*: A description of the benchmarks used for each quality measure
3. The data used to calculate the clinic's current performance (numerator, denominator, and resulting percentage) for the three quality measures
4. The data used to calculate the clinic's baseline(s) and improvement target(s) for the quality measure(s) that the clinic has chosen to demonstrate improvement on (if the clinic chooses to demonstrate improvement over the last year, it will need to show 2 years of data. If the clinic chooses to demonstrate improvement over the last 6 months, it will need to show one year of data.)

Activities that do not meet 2.A.2:

- A clinic does not use the most current benchmark recommended by a relevant health authority.
- A clinic is meeting the benchmark for all three of its selected quality measures at baseline, rather than selecting at least one quality measure for which it is not yet meeting the benchmark at baseline in order to demonstrate improvement.

Specifications for 2.A.3

A clinic is meeting measure 2.A.3 if it is meeting the specifications for both 2.A.0 and 2.A.1, and can demonstrate that it has improved on health disparities in all three of its quality measures in the last 6 or 12 months. The patient subgroup(s) selected for disparity reduction should be meaningful to the clinic's mission or reflective of its patient population. Clinics may choose to align their improvement efforts with existing goals such as those suggested by local CCO Community Health Assessments, or to focus exclusively on their unique patient population. Additional guidance around identifying disparities can be found in the specifications for 2.A.1.

Demonstrating Improvement: Improvement can be demonstrated in either of the following two ways. The data used for the comparison must span either the most recent 12 months (comparing the most recent 6 months to the 6 months before) or the most recent 24 months (comparing the most recent year to the year before).

1. A positive change in the clinic's performance for a specific patient subgroup.
2. A reduction in the gap in the clinic's performance between a patient subgroup and the rest of the patient population.

Examples:

- A clinic is tracking three primary care quality measures: "Diabetes: Hba1c poor control," "Colorectal Cancer screening," and "Breast Cancer screening." It identifies in its performance data that a couple patient subgroups are being screened less for cancer and experiencing higher (HbA1c) levels than their average patient with diabetes. Since Latino/a patients make up 10% of their patient population, they decide to take steps to

close gaps for this subgroup. They are able to demonstrate that, over the past year, they closed the gap between their Latino/a patients and the rest of their patient population by 1% in colorectal cancer screenings, 0.5% in breast cancer screenings, and 3% in Hba1c poor control.

- A solo clinic is tracking three primary care quality measures: "Depression screening," "Oral evaluation for adults with diabetes," and "Cervical Cancer screening." It has identified that its rural patients (of which it has at least 30) are being screened less for depression and oral health than its non-rural patients. It has also discovered that its patients who identify as LGBTQIA2S+ are being screened less for cervical cancer. The clinic takes steps to reduce barriers to care for its rural patients and LGBTQIA2S+ patients and is able to demonstrate better screening rates among these groups over the past 6 months.

Documentation required at a Verification Site Visit:

1. Copy of the specifications used for each of the three quality measures, including the name of qualifying source or measure steward (please note that the 3 quality measures demonstrated during a site visit must match those selected in the online application)
2. The data used to calculate the clinic's current performance (i.e., the last 6 or 12 months) for the three selected quality measures, including a breakdown or summary of the disparities experienced by one or more patient subgroups
3. The data used to calculate the clinic's baseline performance (i.e., the 6 or 12 months preceding the current performance) for the three selected quality measures, including a breakdown or summary of the disparities experienced by one or more patient subgroups)

Activities that do not meet 2.A.3:

- A clinic chooses to demonstrate improvement for a disparity impacting patient subgroup(s) with only a few patients and cannot speak to their rationale for choosing these patients or demonstrate a meaningful selection process.
- A clinic has only reduced a disparity or improved their subgroup performance in some of its three quality measures.
- A clinic can demonstrate a disparity reduction among their selected subgroup(s), but only because their performance among their comparison patient group(s) was reduced.

Additional Resources:

- CMS: Quality Improvement & Interventions
- Eliminating Disparities to Advance Health Equity and Improve Quality (MHA Keystone Center)
- Applying SOGI Data to Clinical Quality Improvement and Decision Support & Building Patient-Centered Medical Homes for LGBT Patients and Families (National LGB Health Education Center)

Standard 2.B – Value-Based Payment

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

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.	**5 points**
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 clinic's patient population.	**10 points**
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 clinic's patient population.	**15 points**

Intent of Standard 2.B

Value-based payment (VBP) is one of Oregon's primary strategies for achieving the "Triple Aim" of better health, better care and lower costs by transitioning away from traditional fee-for-service (FFS) payment models that reward volume over value. VBP can support PCPCH's team-based care and care management efforts that otherwise can't be reimbursed by traditional fee-for-service payments, such as outreach, traditional health workers, care coordination, partnerships with community entities, and other non-billable types of care.

Definitions

Value-based payment (VBP): A payment structure that is not based on fee-for-service and, instead, rewards services associated with quality and cost-effectiveness rather than volume of services. VBPs are sometimes referred to as Alternative Payment Models (APMs).

Value-based payment categories: Please refer to Health Care Payment and Learning Action Network (HCP-LAN) framework for information about the VBP categories relevant to this standard (see Image 2.B on page 48).

Specifications for 2.B.1

A clinic is meeting 2.B.1 if it receives a value-based payment in any of the HCP-LAN categories between 2.C (*Pay-for-Performance*) and 4.C (*Integrated Finance & Delivery Systems*) from at least one payer.

Activities that do not meet 2.B.1:

- A clinic receives a per-member-per-month (PMPM) foundational payment for infrastructure and operations (HPC-LAN category 2.A).
- A clinic receives a payment for reporting on quality metrics but is not required to meet performance benchmarks or targets to receive the payment (HPC-LAN category 2.B).

Specifications for 2.B.2

A clinic is meeting 2.B.2 if it receives a value-based payment in any of the HCP-LAN categories between 2.C (*Pay-for-Performance*) and 4.C (*Integrated Finance & Delivery Systems*) from at least two payers or from one payer that covers at least 20% of the clinic's patient population.

Activities that do not meet 2.B.2:

- A clinic receives a per-member-per-month (PMPM) foundational payment for infrastructure and operations (HPC-LAN category 2.A).
- A clinic receives a payment from a payer for reporting on quality metrics but is not required to meet performance benchmarks or improvement targets to receive the payment (HPC-LAN category 2.B).
- A clinic receives a payment in any HPC-LAN categories between 2.C. and 4.C from one payer but it does not cover at least 20% of the clinic's patient population.

Specifications for 2.B.3

A clinic is meeting 2.B.3 if it receives a value-based payment in any of the HCP-LAN categories between 3.A (*APMs with Shared Savings*) and 4.C (*Integrated Finance & Delivery Systems*) from at least two payers or from one payer that covers at least 10% of the clinic's patient population.

Activities that do not meet 2.B.3:

- A clinic receives a per-member-per-month (PMPM) foundational payment for infrastructure and operations (HPC-LAN category 2.A).
- A clinic receives a payment from a payer for reporting on quality metrics but is not required to meet performance benchmarks or improvement targets to receive the payment (HPC-LAN category 2.B).
- A clinic receives a payment for meeting benchmarks or improvement targets on quality or utilization metrics (HPC-LAN category 2.C).
- A clinic receives a payment in any HPC-LAN category between 3.A and 4.C from one payer but it does not cover at least 10% of the clinic's patient population.

Image 2.B: Alternative Payment Model Categories

Standard 2.C – Patient and Family Involvement in Quality Improvement

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

2.C.1	PCPCH involves patients, families, and caregivers as advisors on at least one quality or safety initiative per year.	**5 points**
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.	**10 points** ***Health Equity Measure***
2.C.3	Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	**15 points** ***Health Equity Measure***

Intent of Standard 2.C

While all clinics aspire to be responsive to the needs of their patients, formalizing the involvement of diverse patients, family members, and caregivers in quality improvement efforts increases a clinic's ability to be responsive to their needs. Though quality improvement is implicit to several other standards, the measures in Standard 2.C provide a roadmap for clinics to engage diverse patients, family members, and caregivers as advisors in quality improvement activities.

Relevant Definitions

Diverse patients: Patients that vary by age, sex, race, ethnicity, primary language, disability, sexual orientation, gender identity, health condition, and length of time as a patient at the clinic, among other characteristics.

Peer support: Support provided to patients, families, and caregivers by a patient of the clinic who has similar life experiences.

Specifications for 2.C.1

A clinic is meeting measure 2.C.1 if it convenes a group of patients, family members, and/or caregivers at least once every 12 months to provide feedback and guidance on how the clinic can improve on a specific area of focus. This group should be representative of the clinics'

diverse patient population, and the clinic must document the guidance gathered during this advisory process.

Examples:

- A clinic hosts a meeting in which a diverse group of its patients, families, and caregivers review and provide feedback on materials before they are distributed to the overall patient population. The clinic documents the materials presented to the group and how their feedback was incorporated.
- A clinic convenes a group of diverse patients, families, and caregiver advisors to evaluate waiting room and front office procedures. The clinic documents what changes are made to their waiting room and front office workflow based on the group's input.

Documentation required at a Verification Site Visit:

Transcripts from a focus group, minutes from a meeting, or communications between identified patient, family, and caregiver advisors

Activities that do not meet 2.C.1:

- Patients, families, and caregiver advisors participate on a health system or organization-wide governing board (to meet 2.C.1, a meeting must be convened by an individual clinic and involve patients, families, and caregiver advisors who receive care at that specific clinic location).
- A clinic only uses feedback from a patient survey for quality improvement activities. It does not convene a group of patients, families, and caregiver advisors that come together to meet and interact with one another.

Additional Resources:

Engaging People with Lived Experience Toolkit (Community Commons)

Specifications for 2.C.2

A clinic is meeting measure 2.C.2 if it continually involves patients, families, and/or caregivers as advisors for ongoing quality improvement, safety, or program development activities at the clinic. This advisory group should be representative of the clinics' diverse patient population.[9]

Examples:

- To help enhance their patients' experience, a clinic maintains a diverse patient, family, and caregiver advisory council (PFAC) that reviews clinic data and quality improvement efforts on a quarterly basis to provide advice and guidance.
- A clinic forms an ongoing quality improvement committee made up of its own patients, patient family members, and caregivers spanning a variety of ages and medical conditions. This team brainstorms solutions to challenges patients face in using the

[9] PCPCHs that are School-Based Health Centers (SBHCs) may use their Youth Advisory Councils (YACs) to meet Measure 2.C.2 so long as they are meeting all specifications.

patient portal, which they monitor and evaluate over the course of a year to make the portal more accessible for all.

- A health system with multiple clinics has a joint patient and family advisory council for three of their rural clinics that are close in distance, have similar patient populations, and share similar circumstances and challenges (such as a lack of local resources). The advisory council includes at least three patients from each location to represent their clinic. Because of the similarities between the clinics, they sometimes develop quality improvement initiatives that are launched at all three locations, but also work hard to develop improvement activities that are tailored to a specific location when prompted by feedback from its respective patients.

Documentation required at a Verification Site Visit:

1. Transcripts from multiple patient focus groups, meeting minutes, or communications between identified advisory group participants from an established, ongoing advisory group
2. "Plan, Do, Study, Act" cycles (PDSAs) or other documentation showing quality improvement, safety, or program development activities that have been implemented and are based upon feedback from advisory group participants

Activities that do not meet 2.C.2:

- The clinic hosts a one-time meeting or gathering of patients, families, and/or caregiver advisors.
- In an organization/health system with multiple clinics: patients, families, and caregiver advisors meet regularly to discuss organization-wide improvements, but they do not represent each unique clinic within the health system. As a result, some clinics within the organization are not represented in system-wide quality improvement initiatives.

Additional Resources:

- Partnering with Patients and Families to Enhance Safety and Quality: A Mini Toolkit (Institute for Patient- and Family-Centered Care)
- Improving Diversity in Patient and Family Advisory Councils (Institute for Patient- and Family-Centered Care)

Transformation in Practice

A pediatric clinic began involving families and caregivers in quality improvement activities after the mother of a child with special health care needs expressed an interest in convening parents whose children had similar health care needs. By facilitating opportunities for families to regularly come together, the clinic not only gathered valuable feedback but helped parents learn how to navigate the complex health system together, ensure that their children received the care that they needed, and provide emotional support to one another.

Specifications for 2.C.3

A clinic is meeting measure 2.C.3 if it is doing both of the following:

- ☑ It is meeting the specifications for PCPCH Measure 2.C.2.
- ☑ It has one or more patients, family members, or caregivers integrated into the clinic as an advisor (e.g., they provide peer support to patients or assist in the training/hiring of clinic staff). There must be an established process for recruiting, training, and supporting these diverse patient, family, and caregiver advisors. Their training should include topics such as HIPAA and signing of a confidentiality statement, safety, infection control, etc.

Examples:

- In addition to having a patient advisory council that meets monthly, a clinic has integrated patients, families, and caregiver advisors who regularly participate in staff training or hiring activities such as interviewing potential new employees.
- A clinic has an ongoing quality improvement committee that includes representation from its diverse patients, as well as integrated patients, families, and caregiver advisors who help facilitate peer counseling, support groups, workshops, or education classes organized by the clinic.
- In addition to a patient advisory group, a clinic has volunteers who welcome new patients as they walk into the clinic, give out new patient orientation packets, and help answer any questions new patients may have. The volunteers also provide the clinic with valuable insight about the kinds of questions and experiences that new patients have.

Documentation required at a Verification Site Visit:

1. Transcripts from multiple patient focus groups, meeting minutes, or communications between identified advisory group participants from an established, ongoing advisory group
2. “Plan, Do, Study, Act” cycles (PDSAs) or other documentation showing quality improvement, safety, or program development activities that have been implemented and are based upon feedback from advisory group participants
3. Description of how at least one patient, family member, and/or caregiver is integrated into the clinic (examples of clinic staff trainings and peer support activities assisted/facilitated by integrated patient advisor)

Activities that do not meet 2.C.3:

Patients, families, and caregiver advisors are engaged with on-going quality improvement efforts but they do not have defined roles in administration or patient care (e.g., hiring or training clinic staff, facilitating peer-support groups, etc.).

Standard 2.D – Quality Improvement

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

2.D.1	PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.	**5 points**
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.	**10 points**
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 clinic. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	**15 points**

Intent of Standard 2.D

Quality improvement is a fundamental aspect of PCPCHs and having a formal quality improvement (QI) strategy can help clinics achieve their goals. While QI is implicit to several other standards, these measures outline a standard pathway to strategic, integrated, clinic-wide improvement. An explicit, comprehensive QI strategy is important for efficiently collecting, analyzing, and acting on data to improve quality of care.

Relevant Definitions

***Multi-disciplinary*:** Staff from multiple roles at the clinic – including providers, support staff, management, and front desk staff.

***Performance data*:** Data collected using standardized processes to assess a clinic's performance with regards to a service or health outcome. Performance data may be collected from health records, surveys, EHR dashboard reports, care gap lists, staff feedback, and other methods.

Specifications for 2.D.1

A clinic is meeting measure 2.D.1 if it uses performance data to identify improvement opportunities and plans, documents, and implements improvement activities within the clinic based on this data.

Examples:

- A clinic is looking to improve A1C scores and does a Plan Do Study Act (PDSA) cycle on expanding lab hours to provide more time for A1C testing. The clinic documents the different PDSA steps to guide their ongoing project decisions.
- A clinic wants to decrease the number of patients that have a high blood pressure reading at the time of their appointment. They decide to use SMARTIE goals (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable) as a framework. They implement a process to complete a second blood pressure check after patients have had some time to get settled into their appointment. The clinic documents each specific action it takes towards its SMARTIE goals as it implements new processes for medical assistants and providers who help track patients' blood pressure.

Documentation required at a Verification Site Visit:

Documentation of a quality improvement project that uses performance data to guide improvement activities

Activities that do not meet 2.D.1:

The clinic implements an improvement project but cannot produce examples of the performance data it used and the actions it took to improve on a clinical process.

Additional Resources:

Science of Improvement: Establishing Measures (Institute for Healthcare Improvement)

Specifications for 2.D.2

A clinic is meeting measure 2.D.2 if it has a multi-disciplinary quality improvement team that regularly reviews data and plans, documents, and implements improvement activities in the clinic.

Note: Solo practitioners can meet the intent of this measure by participating in an ongoing collaborative that covers the topic area of quality improvement and specifically benefits the patients in their clinic.

Examples:

- A clinic has a QI committee that meets regularly to implement PDSA cycles and has representation from every clinic role and department. The clinic documents the progress on each improvement project it is implementing and presents the results to staff.
- A small clinic includes all staff on its QI committee, but there is a defined process for transparent decision-making and the QI committee documents its meeting minutes.

Documentation required at a Verification Site Visit:

1. Documentation of a quality improvement project that uses performance data to guide improvement activities
2. Meeting minutes or other evidence of regular multi-disciplinary improvement team meetings within the past 12 months (prior to PCPCH attestation) and documentation of progress

Activities that do not meet 2.D.2:

Staff member(s) from the clinic participate on a QI committee at an organizational or health system-wide level, but they do not define quality improvement initiatives specific to their clinic or their patient population.

Specifications for 2.D.3

A clinic is meeting measure 2.D.3 if it has both of the following:

- ☑ A multi-disciplinary quality improvement team that regularly reviews data and plans, documents, and implements improvement activities in the clinic.
- ☑ A clinic-wide annual improvement strategy with performance goals that are informed by each of the following: community, patient, family, caregiver, and other stakeholder feedback, publicly reported measures, and areas for clinical and operational improvement identified by the clinic. The improvement strategy must include a monitoring and evaluation methodology, multiple improvement projects, and methods of communication to gather, learn, and apply best practices.

Examples:

- A clinic develops an annual clinic-wide improvement strategy that includes a proactive timeline integrating multiple improvement projects based in SMARTIE goals. It sets priority quality goals and strategically plans to focus on each goal during a specific time period, such as each month or each quarter. In addition, the clinic has a quality team who regularly meets to review, plan, and document the progress of their improvement activities.
- A clinic has a multi-disciplinary quality team that meets regularly to discuss the annual QI strategy and PDSA's they are working on. These PDSA's are developed from QI strategies rooted in multiple sources of performance data and information, as well as the sustainability and feasibility of their implementation across the clinic.
- A clinic is part of a large health system that has a system-wide quality improvement plan for its multiple clinics. The clinic integrates system-wide performance goals into their clinic by working with clinic staff to define/implement QI projects that help meet system-wide goals and benefit its patient population. The clinic maintains its own multi-disciplinary quality improvement team that meets to review, plan, and document their progress.

Documentation required at a Verification Site Visit:

1. A written annual clinic-wide improvement strategy that includes all of the elements described above
2. Documentation of a QI project that uses performance data to monitor, evaluate and guide improvement activities
3. Meeting minutes or other evidence of regular multi-disciplinary improvement team meetings within the past 12 months (prior to PCPCH attestation) and documentation of progress

Additional Tips

Improving health equity

PCPCHs can consider the following tips to ensure that improvements are benefitting all their diverse patients. This could include identifying any potential disparities in your patient population and then developing and implementing specific quality improvement goals and strategies to reduce those disparities. Below are some suggestions:

Begin collecting demographic data on your patients such as their race[10], ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, or other socially determined circumstances. "REALD" is an example of such patient data collection, with templates available on OHA's REALD for Health Care Providers webpage. You can leverage PCPCH staff members from diversity, equity, and inclusion (DEI) groups, patients' registration, data analytics, IT, quality and safety, community outreach, and enabling services to help validate and support data collection.

Stratify your clinic's performance data or quality measures by these types of patient characteristics to identify significant differences in one or more indicators of health, access, or timely, high-quality care.

Use U.S. Census data, community needs assessments (such as the community needs assessments produced by your local CCO), or other local data sources[11] to better ***understand the community in which your clinic is located*** in order to identify additional underserved groups. For example, this information could be used to identify demographics in your community who rarely visit your clinic and help you adjust your services to improve access for these groups.

[10] **Resource:** California Improvement Network's Toolkit to Advance Racial Health Equity in Primary Care Improvement

[11] **Resource:** Oregon Office of Rural Health Primary Care Service Areas

Activities that do not meet 2.D.3:

- A clinic can demonstrate multiple past QI projects but no standardized monitoring or evaluation methodology and/or demonstration of how the projects support the overall annual strategic QI goals.
- A clinic tracks and reports on performance metrics but does not have an annual improvement strategy to identify areas of focus, annual goals and evidence of structured improvement projects.
- A clinic has an annual strategic plan with goals and methods based solely on incentive metrics that are prioritized by a CCO or payer (does not include clinic-specific goals).
- A clinic has an annual strategic plan that only accounts for CCO patients or another population subset and is not relevant to the clinic's entire patient population.

Standard 2.E – Ambulatory Care Sensitive Conditions Utilization

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 25 pts):

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.	**10 points**
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.	**15 points** ***Health Equity Measure***

Intent of Standard 2.E

Ambulatory care sensitive conditions (ACSCs) are acute or chronic health issues that lead to potentially preventable hospitalizations or complications when not treated in a primary care setting. PCPCHs play a critical role in "bending the cost curve" by ensuring that ACSCs are treated well, to the patients' satisfaction, and in the most cost-effective setting. Timely, high-quality, actionable data can help clinics identify patients experiencing unplanned or adverse utilization patterns, as well as patient subgroups experiencing disparities in those utilization patterns, and target areas for improvement. It is important that clinics monitor ACSC utilization measures and disparities that are meaningful to their patient population as a whole.

Relevant Definitions

Ambulatory Care Sensitive Conditions (ACSCs) Utilization Measures: Metrics that reflect the extent to which patients are experiencing potentially preventable hospitalizations, condition advancement, or emergency services. These metrics typically center on hospitalizations, readmissions, condition complications, emergency department utilization, follow-up after these events, resource stewardship, or utilization of relevant preventive health services— either for specific conditions, groups of conditions (e.g., mental health) or for all causes. While there sometimes exists some overlap between ACSC utilization measures and the "primary care quality measures" referenced in PCPCH Standard 2.A, clinics attesting to both standards must select different measures for each.

Health disparities: Differences in the presence of disease, health outcomes, or access to health care services between various populations that are not due to differences in health care needs or patient preferences. In the context of PCPCH Standard 2.E, health disparities refer to a

difference in a PCPCH's performance on an ACSC utilization measure between one or more patient subgroups and its general patient population.

Qualifying ACSC utilization measure lists: The lists of ACSC measures provided by select measure stewards that PCPCHs may choose from to meet PCPCH Standard 2.E. The qualifying ACSC utilization measure lists are included on page 59.

Specifications for 2.E.2

A clinic is meeting measure 2.E.2 if it is doing all of the following:

- ☑ Tracks at least one ACSC utilization measure among its patient population from one of the qualifying lists below. The utilization measure selected must be relevant to the clinic's patient population, and the data used for tracking must be aggregated across all relevant providers and patients in the clinic. For example, if a clinic selects a utilization measure from a CCO Performance Metric list, they must track data for all applicable patients at the clinic, not just Oregon Health Plan members.
- ☑ Analyzes the utilization data to identify patients with unplanned or adverse utilization patterns to inform appropriate interventions.
- ☑ Has a policy and procedure for contacting these patients to evaluate their status and make a follow-up appointment or facilitate other appropriate interventions if needed. The clinic's policy must define the appropriate contact period and include a process for documenting that systematic follow-up was completed. When contacting patients, the clinic should offer care to prevent worsening of a condition, clarify discharge instructions, and encourage follow-up care. Follow-up care may include but is not limited to additional care coordination, physician counseling, telehealth visits, engagement with clinic team members with expertise in care management and/or self-management support (e.g., Traditional Health Workers, nurses, BHCs), or referrals to community resources such as disease or case management and self-management support programs. Clinics are encouraged to partner with community partners where helpful and appropriate.

Qualifying ACSC Utilization Measures Lists:

- CCO Performance Metrics (CCO Incentive Measures & State Quality Measures)
- CMS Core Set of Adult Health Care Quality Measures (Adult Core Set)
- CMS Core Set of Children's Health Care Quality Measures (Child Core Set)[12]
- Core Quality Measures Collaborative (CQMC) Core Quality Measure Sets
- Health Plan Quality Metrics (HPQM) List (See "*Aligned Measures Menu*")
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Merit-based Incentive Payment System (MIPS) Measures

[12] Clinics may use a previous years' Child Core Set if the utilization measure that they are tracking is not included the most recent version.

Example:

A clinic tracks its performance on "*Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence*" and develops procedures to contact patients that have a higher frequency of emergency department visits to ensure that they are scheduled for and receive appropriate interventions in a timely manner. The clinic contacts patients, families, and/or caregivers via phone, patient portal, or letters. These interventions are documented.

Documentation required at a Verification Site Visit:

1. Documentation demonstrating that the clinic is routinely tracking one or more ACSC utilization measure from one of the qualifying lists
2. Policy, procedure, or workflow for tailoring interventions for patients with unplanned or adverse patterns in the utilization measure being tracked

Activities that do not meet 2.E.2

- The clinic infrequently tracks or conducts an ad hoc review of selected PCPCH Utilization Measures.
- The clinic inconsistently contacts patients with high utilization patterns and does not have a clinic-wide strategy or policy in place to help improve utilization patterns.

Additional Resources:

Resources and Tools to Improve Discharge and Transitions of Care and Reduce Readmissions (Agency for Healthcare Research and Quality)

Specifications for 2.E.3

A clinic is meeting measure 2.E.3 if it is doing all of the following:

- ☑ Tracks at least one ACSC utilization measure among its patient population from one of the qualifying lists on page 59. The utilization measure selected must be relevant to the clinic's patient population, and the data used for tracking must be aggregated across all relevant providers and patients in the clinic. For example, if a clinic selects a utilization measure from a CCO Metrics List, they must track data for all applicable patients at the clinic, not just Oregon Health Plan members. If a clinic is attesting to both 2.E.2 and 2.E.3, they may choose either the same utilization measure or two different ones.
- ☑ Analyzes the utilization data to identify one or more patient subgroups that are experiencing disparities in the clinic's performance on its selected measure. Patient subgroups may be defined by characteristics such as race, ethnicity, language, disability status, gender, gender identity, sexual orientation, age, special or complex health needs, social class, geographic region, life circumstances, health-related social needs, or other characteristics relevant to the clinic's patient population.[13]

[13] See *PCPCH Standard 4.C – Organization of Clinical Information* for guidance around collecting demographic data from patients in a trauma-informed and trust-building way.

- ☑ Has a policy and procedure for contacting these patients to evaluate their status and make a follow-up appointment or facilitate other appropriate interventions if needed. The clinic's policy must define the appropriate contact period and include a process for documenting that systematic follow-up was completed. See Measure 2.E.2 for examples of various types of interventions. When contacting patients and facilitating interventions, the clinic should consider this patient subgroups' unique barriers or needs.

Note: A clinic attesting to both 2.E.2 and 2.E.3 must be able to demonstrate that its overall follow-up or intervention strategy for all patients with adverse utilization patterns considers the unique barriers or needs of the patient subgroup(s) experiencing disparities.

Examples:

- A pediatric clinic tracks its performance on "*Plan All-Cause Readmissions*" and has identified that its patients who are Children and Youth with Special Health Care Needs (CYSHCN) are being readmitted at a higher rate than their other patients. The clinic develops procedures to contact the parents of these patients to ensure that they are being scheduled for and receiving appropriate interventions in a timely manner, and that these procedures consider the barriers that these parents face is navigating care.
- A clinic is tracking its performance on "*Ambulatory Care: Emergency Department Visits (AMB-CH)*." It is able to segment utilization data by language and discovers that patients whose primary language is Spanish are visiting the emergency department at a higher rate than their other patients. The clinic already has a follow-up workflow for all patients who demonstrate high risk or high utilization of the emergency department, but in lieu of this disparity the clinic works to ensure that this workflow includes Spanish interpretation and translation services.
- A clinic is tracking its performance on "*Prenatal and Postpartum Care*" and "*Breast Cancer Screening*" and is able to segment its data based on patient address. The clinic finds that rural patients are experiencing a disparity in these measures and decides to incorporate various resources into its existing patient follow-up calls/interventions including transportation options under OHP or local agencies, and information about mammogram mobile van locations.

Documentation required at a Verification Site Visit:

1. Documentation demonstrating that the clinic is routinely tracking one or more ACSC utilization measure from one of the qualifying lists and how it has identified a patient subgroup experiencing a disparity in the clinics' performance
2. Policy, procedure, or workflow for tailoring interventions for patients in this subgroup with unplanned or adverse patterns in the utilization measure being tracked

Activities that do not meet 2.E.3:

- A clinic is tracking at least one ACSC utilization measure but is not able to segment its performance data to identify patient subgroups experiencing disparities.

- A clinic has a process for following up with all patients experiencing adverse utilization patterns in its selected utilization measure, but cannot demonstrate that this process considers the unique barriers or needs of the patient subgroup experiencing a disparity.

Additional Resources:

- Guide to Reducing Disparities in Readmissions (The Disparities Solutions Center)
- Stratifying HEDIS Quality Measures (Race & Ethnicity Stratification Learning Network)
- Enhancing Support for Patients' Social Needs to Reduce Hospital Readmissions and Improve Health Outcomes (Patient Safety Network)

Standard 2.F – PCPCH Staff Vitality

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 10 pts):

2.F.1	PCPCH develops and implements a strategy to improve the vitality of its staff.	**5 points**
2.F.2	PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	**10 points**

Intent of Standard 2.F

Staff vitality contributes to the sustainability of providing high quality, patient-centered care. Activities that support the safety, well-being, work satisfaction, growth, and the overall morale of clinic staff may positively influence the quality of life for everyone at the primary care home, including patients. Health system leaders should make staff well-being a measurable priority, with accountability at the highest level of the organization, and include health care staff in the design and implementation of a comprehensive well-being strategy for staff.

Relevant Definitions

Staff vitality: The state of being strong and active in energy, morale, and/or within physical, mental, and emotional realms which creates a meaningful and productive work life where people are able to reach their fullest professional potential.

Specifications for 2.F.1

A clinic is meeting measure 2.F.1 if it is able to demonstrate an ongoing strategy for addressing staff vitality that includes all of the following:

- ☑ Method(s) used to gather feedback from all employees, to be completed at least once a year
- ☑ How this feedback is shared with entire staff (e.g., email, internal newsletter, all-staff meetings)
- ☑ Actions taken by the clinic based on this employee feedback that directly impact staff vitality

Example:

A clinic uses an employee satisfaction survey to measure stress management needs and gather team-building suggestions from staff. All employees at the clinic are offered the opportunity to provide input. Leadership shares the anonymous SurveyMonkey results during an all-staff meeting, along with a plan on how they will address issues identified in the survey. Based on the feedback, the clinic initiates monthly activities for employees including a walking group, book club, and group discussion on professional development opportunities focused on as trauma-informed care.

Documentation required at a Verification Site Visit:

1. Documentation demonstrating how clinic gathers feedback from staff (e.g., survey questions, meeting minutes, suggestion box comments, etc.)
2. Summary of feedback gathered from and shared with staff
3. Evidence of vitality improvement activities that address specific concerns based on employee feedback

Activities that do not meet 2.F.1:

- After staff feedback has been gathered, a clinic does not share the results with the entire staff.
- The clinic does not implement any activities that address staff vitality based on their feedback.

Specifications for 2.F.2

A clinic is meeting measure 2.F.2 if it is able to demonstrate an ongoing strategy for addressing staff vitality that includes all of the following:

- ☑ Method(s) used to gather feedback from all employees, to be completed at least once a year
- ☑ How this feedback is shared with entire staff (e.g., email, internal newsletter, all-staff meetings)
- ☑ Actions taken by the clinic based on this employee feedback that directly impact staff vitality
- ☑ How these actions or activities are monitored and evaluated for progress or success

Examples:

- A wellness committee develops an anonymous comment box process that employees can use to submit feedback on how their new referral workflows affect their roles. After reviewing the feedback at an all-staff meeting, the clinic makes a few changes in the workflow, and after three months asks for more anonymous feedback from the staff to see if these changes have affected the team's morale.
- A clinic conducts focus groups within each of its departments to discuss how the physical environment, due to new construction, could be more conductive to employees'

well-being. It summarizes feedback at an all-staff meeting and generates ideas from staff about how to address concerns. Within seven months, it initiates changes that improve care team dynamics, and coordinates another round of focus groups. Overall sentiments reflect how much more satisfied employees are with the new office space.

- Questionnaire assessments are distributed annually to evaluate how employees are adapting to systemic changes and gather suggestions they might have, including how new technology could be utilized. The clinic's leadership seeks employee feedback to intentionally improve or maintain staff vitality.
- A clinic uses monitoring and evaluation methods to assess staff vitality activities, such as Plan-Do-Study-Act (PDSA) and Specific-Measurable-Achievable-Realistic-Timely (SMART) goals.

Documentation required at a Verification Site Visit:

1. Documentation demonstrating how clinic gathers feedback from staff (e.g., survey questions, meeting minutes, suggestion box comments, etc.)
2. Summary of feedback gathered from and shared with staff
3. Evidence of vitality improvement activities that address specific concerns based on employee feedback
4. Evaluation methodology or data assessment conducted after vitality activities were implemented (e.g., re-survey questions on implemented activities, PDSA after activities were completed, meeting minutes, etc.)

Activities that do not meet 2.F.2:

A clinic takes action to address staff vitality without evaluating the success of those actions. For example, after receiving feedback from a staff survey that frustrations were high (on a scale of 1-10), a clinic implements new workflows to streamline how they coordinate case management for patients. However, the clinic does not follow-up and measure the difference that the new workflows made. Therefore, despite having a sense that case management is working better for staff and patients, the clinic has not measured the actual impact on staff vitality.

Additional Resources:

PCPCH Program Staff Vitality Toolkit contains additional guidance, suggestions, templates, and examples for how to meet PCPCH Measures 2.F.1 and 2.F.2.

Additional Tip

Evaluating your diverse staff's vitality: PCPCHs can work to improve health equity among their diverse staff by assessing for disparities in job satisfaction, compensation, paid leave, promotions, or other work areas (e.g., inequities that may be experienced by people of color, individuals with disabilities, LGBTQIA2S+ staff, or other subgroups). By setting goals, collecting and analyzing data or feedback, taking action, and routinely monitoring equity, clinics can foster a culture where every voice is welcome, heard, and respected.

Standard 3.A – Preventive Services

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

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.	**5 points**
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.	**10 points**
3.A.3	PCPCH routinely offers or coordinates 90% of all recommended age and sex-specific preventive services.	**15 points**

Intent of Standard 3.A

Preventive care is a core component of primary health care. The intent of this standard is to ensure that PCPCHs routinely provide access to recommended age and sex-specific preventive care, including behavioral and developmental health preventive services, for their entire patient population. The scope of recommended preventive care is determined by the best available evidence.

Recommended Age and Sex Specific Preventive Services

The age- and sex-specific services that meet the intent of Standard 3.A are based on best available evidence. They include:

- Grade A and B Recommendations *(U.S. Preventive Services Task Force)*
- Guidelines for Health Supervision of Infants, Children, and Adolescents *(Bright Futures)*[14]
- ACIP-Recommended Vaccinations *(Centers for Disease Control and Prevention)*
- Women's Preventive Services Guidelines *(Health Resources & Services Administration)*

[14] See 2023 Summary Table of Recommendations for Preventive Pediatric Health Care provided by Bright Futures and the American Academy of Pediatrics.

- Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children *(Health Resources & Services Administration)*
- Standards of Care for Children and Youth with Special Health Care Needs: Pediatric and Primary Care *(AMCHR & NASHP, see pages 9-11)*

Specifications for 3.A.1

A clinic is meeting measure 3.A.1 if it routinely offers or coordinates each of the four types of recommended age- and sex-specific preventive services listed below to its patients based on best available evidence.

1. **Use of templates, standard forms, or flowsheets to document common screening, preventive services, counseling, or anticipatory guidance**
   Examples: well child examinations, pap smears, Medicare wellness examinations, tobacco use and alcohol misuse screening and counseling

2. **Orders and results for common screening tests**
   Examples: lipid levels, diabetes mellitus screening

3. **Routine preventive procedures**
   Examples: immunizations, mammograms, colonoscopies

4. **Standardized pre-visit planning processes** such as "scrubbing patient records" to proactively find preventive care needs or "huddling" to review expected patient-specific care needs

Example:

A health care team member or dedicated care coordinator is responsible for the provision and coordination of preventive services for the clinic's patient population, which include screening questions, appointments, procedures, test/labs, and scrubbing patient records the day before an appointment to identify patients in need of preventive services.

Additional Tip

Evidence-based preventive care

If your clinic uses an EHR template or health maintenance module for preventive care, it is considered best practice to review them regularly to ensure the preventive services offered are aligned with the most current evidence-based recommendations.

Documentation required at a Verification Site Visit:

Policy, procedure, or workflow that includes how patients due for preventive services are proactively identified

Activities that do not meet 3.A.1

- Clinic does not have pre-visit planning processes and is unable to determine which age-appropriate preventive services a patient is due for.
- Clinic does not ensure that screenings are performed on a regular basis as recommended based on sex.

Additional Resources:

Best practice clinical guidelines for transgender patients, including gender-appropriate and gender-affirming services and procedures:

- Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2016) (University of California, San Francisco)
- Learning Modules: Behavioral Health Care for LGBTQIA+ People (National LGBTQIA+ Health Education Center)

Specifications for 3.A.2

A clinic is meeting measure 3.A.2 if it is doing both of the following:

- ☑ Routinely offers or coordinates each of the four types of recommended age- and sex-specific preventive services listed in 3.A.1 to its patients based on best available evidence.
- ☑ Has an improvement plan to increase the number of recommended age- and sex-specific preventive services provided to its patient population. The plan must include tracking and analyzing data related to provision/coordination of preventive services, identification of gaps in care, a strategy for improving gaps in care, and data evaluating the effectiveness of the improvement strategy.

Examples:

- A clinic tracks which patients are due for a colonoscopy, the number of patients that completed colonoscopy, identifies care gaps to ensure patients due for colonoscopy are scheduled and complete the service, and enters the screening results in the patient's record. The clinic has a documented strategy to identify and close care gaps in preventive services such as colonoscopy.
- A clinic has an intake process which allows them to identify patients whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. The clinic uses this clinical information to identify patients in need of cervical cancer screening, breast cancer screening, and prostate cancer screening. The clinic develops a documented strategy based on the most current recommendations to increase the needed screenings among these patients.

Additional Tip

Exploring gaps in equity

When identifying gaps in preventive services to improve on, PCPCHs may want to consider subpopulations that face barriers to care such as those defined by race, ethnicity, language, disability status, gender, gender identity, sexual orientation, age, special or complex health needs, social class, geographic region, life circumstances, health-related social needs, or other characteristics relevant to the PCPCH's patient population.[15]

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow (e.g., gap report) that includes how patients due for preventive services are proactively identified
2. An improvement plan that contains all required elements listed in the specifications

Activities that do not meet 3.A.2:

- The clinic only tracks care gaps for a sub-section of patients based on payer type.
- The clinic does not have an improvement strategy for preventative service gaps in care.

Specifications for 3.A.3

A clinic is meeting measure 3.A.3 if it is offering or coordinating 90% of the recommended preventive services listed in Table 3.A that are appropriate for its patient population. If the clinic is not able to deliver a preventive service(s) itself, it must have a process that ensures all patients can access applicable services elsewhere, as well as coordinate with external providers to ensure that screening results and recommended next steps are added to the patients' medical record. The percent of recommended services must be calculated using the specifications below and Table 3.A on pages 70-73 of this guide. A PCPCH Standard 3.A.3 Calculation Tool[16] is available on the PCPCH Resources & Technical Assistance webpage to help clinics determine their percentage based on which preventive services are applicable to their patient population.

Numerator: Number of recommended services in table below that are directly coordinated or provided by the clinic.

Denominator: Number of recommended services in table below that apply to clinic population.

[15] See PCPCH Standard 4.C – Organization of Clinical Information for guidance around collecting demographic data from patients in a trauma-informed and trust-building way.

[16] This link will open an excel document that contains the tool. Please complete Columns E and G, and your clinic's percentage will be automatically generated at the bottom of the list (cell 105-I).

Example:

A pediatric clinic offers or coordinates 20 out of the 22 preventive services in the table that apply to children (20 ÷ 22 = 91%).

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow (e.g., gap report) that includes how patients due for preventive services are proactively identified
2. List of age- and sex-specific preventive services offered and applicable calculation to demonstrate meeting the 90% threshold

Activities that do not meet 3.A.3:

A clinic offers many preventive services but does not consistently offer or coordinate 90% of the preventive services in the table below that are appropriate for their population (see calculation instructions).

Table 3.A – Recommended Preventive Services

In addition to the alphabetized list below, a PCPCH Standard 3.A.3 Calculation Tool is available to help clinics determine their percentage based on which preventive services are applicable to their patient population. To use this Microsoft Excel tool, please complete Columns E and G, and your clinic's percentage will be automatically generated at the bottom of the list (cell 105-I).

Table Source Key:

- AAN - American Academy of Neurology
- ACIP - Advisory Committee on Immunization Practices
- BF - Bright Futures
- HRSA - Health Resources & Services Administration
- USPSTF - U.S. Preventive Services Task Force

Recommended Service	Source	Sub-population
Abdominal Aortic Aneurysm	USPSTF	Men ages 65-75 who have ever smoked
Abuse (IPV, DV, EA & vulnerable adults) Screening & Counseling	USPSTF, HRSA	Adolescents and adult women
Age-Appropriate Anticipatory Guidance	BF	Infants, children, and adolescents
Anemia Screening	BF	Infants, children, and adolescents
Anxiety Screening	HRSA, USPSTF	Adolescents and adults (including pregnant and postpartum persons)
Autism Spectrum Disorder Screening	BF	Children
Bacteriuria Screening	USPSTF	Pregnant persons

Recommended Service	Source	Sub-population
BRCA Screening and Counseling	USPSTF	Women with a personal or family history of breast, ovarian, tubal or peritoneal cancer
Breast Cancer Risk-Reducing Medication	USPSTF	Women aged 35 years or older at increased risk for breast cancer
Breast Cancer Screening	HRSA, USPSTF	Women ages 40 to 74 years
Breastfeeding Interventions	USPSTF, HRSA	Pregnant and postpartum persons
Cervical Cancer Screening	USPSTF, HRSA	Women ages 21 to 65 years
Cervical Dysplasia	BF	Adolescents
Chlamydia Screening	USPSTF	Women
Cognitive Impairment Assessment	AAN	Symptomatic adults or when they or a close contact have expressed concerns
Colorectal Cancer Screening	USPSTF	Adults ages 45-75 years
Comprehensive Newborn Screening[17]	BF, HRSA	Newborns
Contraception Counseling and Services	HRSA	Adolescent and adult women
Critical Congenital Heart Defect Screening	BF	Infants
Depression and Suicide Risk Screening	BF, USPSTF	Adolescents and adults (including pregnant and postpartum persons, as well as older adults)
Developmental Surveillance and Screening	BF	Infants, children, and adolescents
Diabetes Mellitus After Pregnancy Screening	HRSA	Women with history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus
Dyslipidemia Screening (Cardiovascular Health)	BF	Children and adolescents
Falls Prevention	USPSTF	Community-dwelling adults 65 years or older who are at increased risk for falls

[17] See 2023 Summary Table of Recommendations for Preventive Pediatric Health Care *(BF & AAP)* and Recommendations on Heritable Disorders in Newborns and Children *(HRSA)*.

Recommended Service	Source	Sub-population
Folic Acid Supplementation & Preventive Medication	USPSTF	Persons planning to or who could become pregnant
Gestational Diabetes Screening	HRSA, USPSTF	Pregnant persons at or after 24 weeks gestation (preferably between 24 and 28 weeks) and high-risk women before 24 weeks
Gonococcal Ophthalmia Prophylaxis Preventive Medication	USPSTF	Newborns
Gonorrhea Screening	USPSTF	Women
Healthy Diet and Physical Activity Counseling	HRSA, USPSTF	Adults with cardiovascular disease risk factors
Healthy Pregnancy Weight Counseling & Interventions	USPSTF	Pregnant persons
Hearing Screening	BF	Infants, children, and adolescents
Hepatitis B Risk Assessment & Screening	USPSTF, BF	Infants, children, adolescents, pregnant women, and adults at increased risk for infection
Hepatitis C Screening	USPSTF, BF	Adolescents and adults up to 79 years
HIV Preexposure Prophylaxis	USPSTF	Persons at increased risk of HIV acquisition
HIV Screening	BF, HRSA, USPSTF	Pregnant persons, adolescents, and adults ages 15-65 as well as high-risk younger adolescents and older adults
Hyperbilirubinemia Screening	BF	Infants
Hypertension/Blood Pressure Screening	USPSTF, BF	Children and adults, and hypertensive disorder screening for pregnant persons
Lead Screening	BF	Infants and children
Lung Cancer Screening	USPSTF	High risk adults ages 50 to 80 years
Maternal/Perinatal Depression Screening, Counseling, and Interventions	USPSTF, BF	Pregnant and postpartum persons
Obesity Screening, Counseling, and Intervention	BF, USPSTF	Children, adolescents, and adults with a body mass index (BMI) of 30 or higher
Oral Health Screening and Interventions	USPSTF, BF	Infants, children, and adolescents
Osteoporosis Screening	USPSTF	Women 65 years or older and at-risk post-menopausal younger women

Recommended Service	Source	Sub-population
Pediatric Behavioral/Social/Emotional Screening	BF	Infants, children, and adolescents
Prediabetes and Type 2 Diabetes Screening	USPSTF	Adults ages 35 to 70 years who have overweight or obesity
Preeclampsia Prevention: Aspirin	USPSTF	Persons who are at high risk for preeclampsia
Rh(D) Incompatibility Screening	USPSTF	Pregnant women
Routine Vaccination/Immunization	BF, ACIP	Infants, children, adolescents, and adults
Sexually Transmitted Infection	BF, HRSA, USPSTF	Sexually active adolescents and at-risk adults
Skin Cancer Behavioral Counseling	USPSTF	Adolescents, young adults, children, and parents of young children
Statin Preventive Medication	USPSTF	Adults ages 40 to 75 years who have 1 or more CVD risk factors
Sudden Cardiac Arrest/Death Risk Assessment	BF	Adolescents
Syphilis Screening	USPSTF	Pregnant women and other high-risk persons
Tobacco Use Assessment, Counseling, and Interventions	BF, USPSTF	School-aged children, adolescents, adults, and pregnant persons
Tuberculosis Screening	BF, USPSTF	Children and populations at increased risk
Unhealthy Alcohol Use Screening & Interventions	USPSTF, BF	Adolescents and adults, including pregnant women
Unhealthy Drug Use Screening	USPSTF, BF	Adolescents and adults
Urinary Incontinence Screening	HRSA	Women
Vision Screening	BF, USPSTF	Infants, children, and adolescents
Well Woman Annual Preventive Visits	HRSA	Adolescents and adult women

Standard 3.B – Medical Services

This is a must-pass standard. Clinics must, at a minimum, meet measure 3.B.0 to qualify for PCPCH recognition.

Measure

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.	**Must Pass**

Intent of Standard 3.B

Acute medical care, chronic medical care, and preventive services are core components of primary health care. The intent of this standard is to ensure that PCPCHs view these services as key responsibilities of the primary care home and routinely provide access to this range of care for all their patients.

Specifications for 3.B.0

A clinic is meeting measure 3.B.0 if it routinely provides all the following categories of care:

1. **Acute care for minor illnesses and injuries.**
   Examples: respiratory infection, musculoskeletal injuries, urinary tract infection

2. **Ongoing management of chronic conditions commonly seen in the clinic's population with coordination of specialty referrals as needed.**
   Examples: diabetes, asthma, obesity, chronic pain, depression, ADHD, hypertension

3. **Office-based procedures and diagnostic tests.**
   Examples: suturing of minor lacerations, splinting and casting, injections, biopsies, point-of-care urinalysis, x-ray, spirometry, EKG

4. **Age and sex-specific preventive services[18], including ACIP-recommended immunizations.[19]** If recommended vaccines are not offered onsite, the clinic must show evidence of closed-loop referrals to partnering organizations.

[18] See *PCPCH Standard 3.A* for examples of age and sex-specific preventive services.

[19] Centers for Disease Control and Prevention (2020): Vaccine-Specific Recommendations from the Advisory Committee on Immunization Practices (ACIP).

5. **Patient education and self-management support.**[20]
   Examples: age-appropriate anticipatory guidance at well child checks for safety, sleep, exercise, nutrition; diet and exercise counseling; instruction on self-management and home monitoring of chronic diseases such as diabetes and hypertension. Patient education and self-management support should be culturally and linguistically appropriate when possible.

Activities that do not meet 3.B.0:

The clinic only provides some of the categories of care listed.

[20] See PCPCH *Standard 6.B –Education and Self-Management Support* for definitions and descriptions.

Standard 3.C – Behavioral Health Services

This is a must-pass standard. Clinics must, at a minimum, meet measure 3.C.0 to qualify for PCPCH recognition.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 35 pts):

3.C.0	PCPCH has a routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.	**Must Pass**
3.C.2.a	PCPCH collaborates or is co-located, and coordinates care, with specialty mental health, substance use disorder, and developmental providers.	**10 points**
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.	**10 points**
3.C.3	PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	**15 points**

Intent of Standard 3.C

Assessment and appropriate intervention for mental health, substance use, developmental, behavioral, or social delays is a core component of primary health care. The evidence is clear that coordination and integration of care for individuals with mental health, substance use, developmental, behavioral, or social conditions is strongly associated with improved health outcomes. The intent of this standard is to ensure that PCPCHs routinely assess their patients, and provide appropriate treatment, referrals, and care coordination for these conditions.

Relevant Definitions

Pharmacotherapy: The treatment of a disorder or disease with medication. In the treatment of addiction, medications are used to reduce the intensity of withdrawal symptoms, alcohol and other drug cravings, and the likelihood of use or relapse for specific drugs by blocking their effect.
Recovery support(s): Referring patients with substance use disorders to appropriate services outside of the scope of the primary care home. This can include community supports such as

peer-to-peer recovery groups, "Recovery Café", clinician-led group visits within the medical home, faith-based programs, counseling, and behavioral health services.

Substance use disorders: These occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Specifications for 3.C.0

A clinic is meeting measure 3.C.0 if it conducts universal screenings of its patients for mental health, substance use disorder, and developmental, behavioral, or social delays (as appropriate). The clinic should identify and document its process for patients who have a positive screen. Additionally, the clinic must use and be able to provide an updated list of community-based referrals and resources for commonly diagnosed mental health conditions, substance use disorders, or developmental delays that meet the needs of their patient population.

Activities that do not meet 3.C.0:

- A clinic provides new patient intake forms with questions about mental health and substance use, but there is no other defined, routine screening strategy for these issues beyond the new patient appointment.
- Screening takes place only at provider discretion or based upon diagnosis.
- A clinic only screens one age group or type of demographic instead of screening all its patients, as appropriate.
- A clinic screens patients for behavioral health conditions but does not have a defined strategy to respond to positive screens or refer patients to external providers when needed.

Specifications for 3.C.2.a

A clinic is meeting measure 3.C.2.a if it collaborates and coordinates, has a cooperative referral process, or is co-located with specialty mental health, substance use, and developmental providers including a mechanism for co-management (as needed). The cooperative referral process may include the following elements:

- Reason for referral and relevant clinical information
- Tracking referral status
- Following up to obtain specialist's report
- Agreements with specialists for co-management
- Systematic, two-way communication and exchange of patient information

Clinics with co-located specialty mental health, substance use, and developmental providers must also have a cooperative referral process with specialty behavioral health providers external

to the clinic to meet measure 3.C.2.a. This ensures that patients are still receiving the types of behavioral health services that are not offered by the clinic onsite. The collaboration, coordination, co-location, or cooperative referral process needs to involve a systematic, two-way communication method or shared medical records. Sharing medical records does not require use of the same EHR but does require the exchange of patient information.

Examples:

- A clinic refers patients with positive PHQ9 screenings to a co-located mental health provider. The clinic's behavioral health referral coordinator assists with updating records and setting up the appointment. A reminder is set to check in with the patient after their behavioral health appointment to make sure it was successful. The co-located provider shares an EHR with the clinic, so primary care providers are able to review their patients' chart notes from the co-located behavioral health appointment. For other types of behavioral health providers (e.g., development and substance use specialists), the clinic has a cooperative referral process with external specialists.
- A pediatric clinic refers patients with positive MCHAT screenings for further developmental assessments. The referral coordinator works with the parents, the school, and local developmental testing center to ensure that appointments are made and all questions are answered. After the appointment, the referral coordinator facilitates a call between the care coordinator, the school, and the external developmental testing center to go over the results of the additional assessments. They also track the referral to make sure they are receiving all documentation from external providers and the school. The clinic has similar cooperative referral protocols when its adolescent patients screen positive for mental health or substance use needs.
- A family clinic has implemented the Collaborative Care Model (CCM) for its adult population and also has cooperative referral relationships with other behavioral health and developmental providers to meet the needs of its child and adolescent patients as well as adult patients with more complex mental health needs.

Additional Tip

Ensuring appropriate behavioral health care

Patients often face barriers in accessing and utilizing behavioral health services such as differences in health literacy, language, background, and life circumstances. PCPCHs can take steps to ensure that the behavioral health providers in their referral network, on-site, and telemedicine network are culturally and linguistically appropriate for their unique patient population and accessible by individuals with disabilities. Clinics can also consider strategies for connecting individual patients with the behavioral health services most appropriate for their background and needs.

Documentation required at a Verification Site Visit:

Evidence of referrals to specialty providers commonly used for entire patient population that address mental health, substance use, developmental, behavioral, or social conditions

Activities that do not meet 3.C.2.a:

A clinic makes referrals to, or is co-located with, behavioral health providers but does not engage in ongoing two-way communication, collaboration, or coordination as a part of the patient's care.

Specifications for 3.C.2.b

A clinic is meeting measure 3.C.2.b if it provides medication treatment (pharmacotherapy) to patients with substance use disorders and also refers them to recovery supports such as community support groups, peer recovery support services, behavioral health, counseling, or twelve-step groups. The clinic must have a process for following up with these patients after referrals to ensure completion or determine barriers.

Examples of Pharmacotherapy:[21]

Alcohol Use Disorders:	*Opioid Use Disorders:*
Acamprosate	Methadone
Extended-release injectable naltrexone	Buprenorphine

Documentation required at a Verification Site Visit:

Policy, procedure, or workflow demonstrating strategy for providing pharmacotherapy to patients with substance use disorders and referring patients for behavioral counseling or recovery supports

Activities that do not meet 3.C.2.b:

- For the purposes of 3.C.2.b, pharmacotherapy does not include Oral Naltrexone or Nicotine replacement therapy (e.g., gum, patches, lozenges, inhalers, etc.).
- A clinic provides pharmacotherapy to its patients but does not refer them to recovery supports or follow up with them after these referrals.

Specifications for 3.C.3

A clinic is meeting measure 3.C.3 if it has an integrated licensed behavioral health clinician (i.e., MD, PhD, PsyD, PMHNP, LCSW, LPC, LMFT) trained to work in a primary care setting delivering a broad array of comprehensive, evidence-based behavioral health services for mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care,

[21] There may be other pharmacotherapy medications not listed here.

and ineffective patterns of health care utilization. Behavioral health services should be available for enough hours each week to adequately address the needs of the clinic's patient population.

A clinic must meet all the following criteria to be considered as having integrated behavioral health services:

- ☑ A behavioral health provider is available for same-day open access services including warm hand-offs, brief assessments, and interventions for patients and families, consultations to primary care clinicians and other care team members, and participation in collaborative treatment planning and co-management with physical providers (pre-visit planning, daily huddles, case conferences, consults, etc.).
- ☑ Physical and behavioral health providers use the same medical record system.
- ☑ The clinic utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of its patient population.
- ☑ If the clinic is providing integrated behavioral health services via telehealth, patients must have the option of coming into the clinic for these services if they don't have access to audio/visual devices or privacy at home.
- ☑ For patients that require specialty services or a level of care that is not provided at the clinic (e.g., patients with psychiatric needs or developmental disorders), the clinic has written protocols for referrals to appropriate specialist(s) and hospitalization if clinically indicated and co-manages care with the external behavioral health providers that patients are referred to.

Behavioral health services may be provided using telehealth if the clinic offers all its patients the option of an in-person or onsite visit with its integrated behavioral health provider(s) when preferred or needed. Please contact pcpch@oha.oregon.gov if you have questions about meeting this onsite requirement.

Activities that do not meet 3.C.3:

- A behavioral health provider is available, but the clinic does not meet the full criteria for integrated behavioral health services described in the specifications section of measure 3.C.3.
- Behavioral and physical health providers practice in the same location, but they do not have meaningful communication with one another or coordinate patient care.
- For patients that require referrals to external behavioral health providers, the clinic faxes chart notes between the clinic and external behavioral health providers but there is no evidence in the medical record of two-way communication between clinicians and specialty providers regarding co-management of patients' plan of care.

Standard 3.D – Health-Related Social Needs

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 25 pts):

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.	**10 points** ***Health Equity Measure***
3.D.3	PCPCH has a routine assessment to identify health-related social needs (HRSNs) 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.	**15 points** ***Health Equity Measure***

Intent of Standard 3.D

Health-related social needs (HRSNs) such as housing instability, transportation, food insecurity, and exposure to interpersonal violence directly impact health outcomes. The intent of this standard is for PCPCHs to assess and, when possible, intervene in patients' HRSNs as part of routine wellness care.

Relevant Definitions

***Community-based resource/agency*:** A public or private organization that is representative of a community or a significant segment of a community and works to meet community needs.

Health-Related Social Needs (HRSN): Social barriers which affect people's ability to maintain their health and well-being. Examples include housing instability, lack of housing quality, food insecurity, interpersonal violence, lack of transportation, utility needs, insufficient education or training, insufficient employment or income, etc.

***Referral tracking*:** A clinic engages in referral tracking (sometimes referred to as "closed-loop referrals") if it keeps a record of referrals, referral follow-up, and referral statuses. The following information should be documented:

- Referral information (i.e., service, specialist, organization)
- The results of referral follow-up activities (i.e., whether contact was achieved, barriers that prevented patients from completing a referral, and any attempts to address those barriers)
- The final outcome of the referral (i.e., whether patients received the appointment/ service)

Specifications for 3.D.2

A clinic is meeting measure 3.D.2 if it routinely screens or assesses its entire patient population for at least three health-related social needs and refers patients with positive screens to relevant community-based resources. Clinics may either conduct this screening directly or partner with external entities.

Examples of HRSN Assessment tools:

OHA has approved several HRSN screening tools for CCOs. Clinics should consider using one of these approved tools if appropriate for their patient population, but can choose another tool that is not on this list. The full list of OHA-approved social needs screening tools is available on OHA's Social Needs Screening Tools webpage.

Examples of Community-Based Resources:

After a positive HRSN screening, a clinic might refer patients to organizations such as (but not limited to):

- Local food banks
- Farmers markets
- Community recreation centers
- Religious based organizations
- Department of Human Services
- County public health departments

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating strategy for assessing health-related social needs of entire patient population
2. Assessment tool or screening questions used

Activities that do not meet 3.D.2:

Providers assess the health-related social needs of their patients on an ad-hoc basis. The assessment is not routine, systematic, or given to their entire patient population.

Additional Tips

Trauma-informed screening

PCPCHs can consider the following strategies for approaching HRSN screening in a safe and trauma-informed way:

- To reduce screening fatigue and build familiarity, consider partnering with external entities that may already be collecting HRSN about your patients (e.g., CCOs, community-based organizations, etc.) or integrating the screening into standard processes and workflows such as intake paperwork, check-ins (electronic or paper), and other forms of data collection that patients are already used to filling out.
- To facilitate trust and engagement, provide patients with some brief background on why this information is being collected and how it will be used to improve their health or the quality of their care.
- Take steps to ensure that the way you are storing, transmitting, or accessing HRSN information acknowledges the safety and privacy concerns of your patients.
- Consider which roles at the clinic are best equipped to collect this information and ensure staff are trained in empathetic inquiry, trauma-informed practices, and culturally and linguistically appropriate care. Traditional Health Workers are often well-suited to assist clinics in understanding and addressing the deeper root causes of HRSN within their communities.
- Honor patient preferences around what types of information they want to share and what types of resources they would like to be referred to (if any).

Specifications for 3.D.3

A clinic is meeting measure 3.D.3 if it is doing all of the following:

- ☑ Routinely screens or assesses its entire patient population for at least three health-related social needs. Clinics may either conduct this screening directly or partner with external entities.
- ☑ Analyzes data to identify target populations or most prevalent HRSNs among its patient population.
- ☑ Engages in one or more of the following population-based interventions for at least one HRSN identified in its patient population:
    - Clinic offers direct services such as vouchers, a workshop or program, development of self-management resources, or other forms of direct support.
    - Clinic partners with a community-based organization or external entity to collaboratively provide direct services.
    - Clinic refers its patients to HRSN service provider organizations and tracks those referrals to completion (i.e., closed-loop referrals). See definitions section for expectations around referral tracking.

The intervention(s) should be tailored to effectively accommodate patient needs and clinic resource capacity. Ideally, clinics will routinely assess the intervention to ensure it still meets the needs of their patients.

Examples:

- A clinic uses the PRAPARE tool to assess the health-related social needs among its entire population. Upon analyzing the data gathered, it finds transportation to be the most prevalent need among its population. In light of this information, the clinic works with local agencies to create a transportation assistance program for its patients (including bus vouchers).
- A clinic screens each of its patients for health-related social needs and analyzes the results to find that many of its patients on the Oregon Health Plan are experiencing housing insecurity. In response, the clinic works with the patient's CCO which has a partnership with a local housing assistance organization. Patients with a positive screen for housing insecurity are referred to the housing organization. The CCO updates the clinic on the progress of the patient in receiving housing—which is updated in the patients' chart notes.
- A clinic screens each of its patients for health-related social needs and analyzes the results to find that many of its patients struggle with utility needs. The clinic uses a closed-loop community referral system (e.g., a Community Information Exchange such as Unite Us) to refer its patients to utility assistance resources and track their progress in receiving assistance. Patients' charts are updated with their status, such as whether they were able to connect with utility assistance and/or what the remaining barriers might be.

- A pediatric clinic assesses all its patients for health-related social needs and finds that inadequate nutrition is a significant barrier to their patients' health. In response, the clinic works with a community nutritionist and develops a self-management tool for parents and pediatric patients on how to improve the nutrition of their daily meals.
- A clinic screens each of its patients for health-related social needs, analyzes the results and identifies that many of their Medicaid patients are experiencing a lack of food stability. On behalf of the patient, the clinic's traditional health worker or primary care provider can request "flexible services" from the patients' CCO. For example, the request may include funds or services for food supports, such as grocery delivery, food vouchers, or medically tailored meals.[22]

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating strategy for assessing health-related social needs of entire patient population
2. Assessment tool or screening questions used
3. Data demonstrating the health-related social needs experienced by the clinic's overall patient population (e.g., reports, lists, descriptions)
4. Evidence of a population-based intervention implemented in response to patients' identified needs (i.e., evidence of direct HRSN assistance, a collaborative partnership with a community-based agency, or closed-loop referrals)

Activities that do not meet 3.D.3:

- A clinic offers health-related social needs interventions, but they are not based in a needs assessment of their overall population.
- Data on health-related social needs is collected through provider discretion only, on an ad hoc basis, without routine assessment.
- A clinic engages in non-cooperative referrals with no follow up or coordination.
- A clinic uses a Community Information Exchange (CIE) such as Unite Us or a similar system to track HRSN referrals, but cannot demonstrate that that this meets the needs of target populations or the most prevalent HRSNs among its patient population (e.g., a clinic finds that its most prevalent HRSN is food insecurity, but there are no local food-related resources available through the CIE platform and it has not developed an alternative intervention for meeting patients' nutritional needs).

[22] See OHA's Flexible Services webpage for more information about flexible services.

Standard 3.E – Preventive Service Reminders

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

3.E.1	PCPCH generates lists of patients who need reminders for preventive services and ensures that they are sent appropriate reminders.	**5 points**
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.	**10 points**
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.	**15 points** ***Health Equity Measure***

Intent of Standard 3.E

Preventive care is a core component of primary health care. PCPCHs that proactively outreach to patients, families, and caregivers about preventive services help facilitate timely completion of recommended screenings and interventions. Clinics can also work towards closing gaps in preventive care utilization by developing alternative outreach strategies for those experiencing disparities.

Specifications for 3.E.1

A clinic is meeting measure 3.E.1 if it uses patient information, clinical data, and evidence-based guidelines to identify patients in need of preventive services and has a process for sending them preventive service reminders.

Examples:

- A clinic mails a letter, postcard, or other reminders to relevant patients ages 24-65 years who have not had a pap test in three years asking them to schedule an appointment for a well-woman exam.
- A clinic calls every patient with a diabetes diagnosis that does not have a recorded HbA1c in the last 6 months to ask them to come in for a lab draw. It documents that those calls were made.
- A clinic sends a portal message to patients who are due for a colorectal cancer screening. By sending this reminder though the portal, it is automatically documented in the patient's chart.

Activities that do not meet 3.E.1:

- A clinic posts signs in the clinic or materials on the website about recommended preventive services.
- A clinic sends out a clinic newsletter to patients with a non-personalized list of ages and recommended preventive services.

Specifications for 3.E.2

A clinic is meeting measure 3.E.2 if it uses patient information, clinical data, and evidence-based guidelines to identify patients in need of preventive services, has a process for sending them appropriate preventive service reminders, and has a process for tracking recommended preventive services to completion.

Example:

A clinic maintains a running list of all patients who are due for a mammogram, colorectal cancer screening, and cervical cancer screening. It tracks its outreach efforts to help patients schedule an appointment and the completion of the screening. Completion of services are documented in the chart.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating clinic's strategy for identifying patients in need of preventive services, sending them appropriate preventive service reminders, and ensuring that preventive services are completed
2. Examples of communications with patients, families, or caregivers reminding them of preventive services that are due

Activities that do not meet 3.E.2:

A clinic reminds its patients of upcoming preventive services that are due, but it does not track if the recommended preventive services have been completed.

Additional Tip

Health literacy in reminders

Clinics working on making their preventive services reminders more effective for a diverse population of patients can take steps to ensure that the reminders are culturally and linguistically appropriate, at an appropriate health literacy level, and accessible by individuals with disabilities. Providing additional reminders to patient-defined and designated family and caregivers (especially using multiple channels such as a phone call to the patient and an email to the patient's adult child) can support the patient in obtaining the recommended preventive services.

Specifications for 3.E.3

A clinic is meeting measure 3.E.3 if it is doing all of the following:

- ☑ Meets all of the specifications in 3.E.2.
- ☑ Has identified a subgroup of patients experiencing at least one disparity in preventive services. Patient subgroups may be defined by characteristics such as race, ethnicity, language, disability status, gender, gender identity, sexual orientation, age, social class, geographic region, life circumstances, health-related social needs, children with special or complex health needs, or other characteristics relevant to the clinic's patient population.
- ☑ Has developed an alternative reminder or outreach strategy for this patient subgroup.

Examples:

- A clinic runs a report of all patients who are due for a mammogram. The clinic notes that patients who have identified Spanish as their primary language are not scheduling mammogram appointments at the same rate as patients who have identified English at their primary language. The clinic develops mammogram reminders in Spanish and sends them to the relevant patients who have identified Spanish as their primary language.
- A clinic runs a report on children due for a Well Child Exam and notes that parents of children with special health care needs are not scheduling appointments at the same rate as those of other children in the clinic. The clinic revises its workflow so that the care coordinator is the staff member contacting these families to schedule an appointment, since the care coordinator already has an existing relationship with these families and can assist with any barriers to setting and keeping an appointment.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating clinic's strategy for identifying patients in need of preventive services, sending them appropriate preventive service reminders, and

ensuring that preventive services are completed—including for patients who experience disparities in preventative services.

2. Examples of general communications with patients, families, or caregivers reminding them of preventive services that are due
3. Example(s) of alternative communications or outreach strategies for patients, families and caregivers who experience disparities in a preventive service.

Activities that do not meet 3.E.3:

- A clinic reminds its patients of upcoming preventive services that are due and tracks them to completion but does not identify a patient subgroup that experiences a disparity in a preventive service.
- A clinic identifies a patient subgroup experiencing a disparity in a preventive service but does not develop an alternative reminder or outreach strategy for those patients.

Standard 3.F – Oral Health Services

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 points):

3.F.1	PCPCH screens or assesses its patients for oral health needs.	**5 points**
3.F.2	PCPCH screens or assesses its patients for oral health needs and provides age-appropriate interventions.	**10 points**
3.F.3	PCPCH provides oral health services by dental providers.	**15 points**

Intent of Standard 3.F

Preventive care and early intervention to treat disease improve whole-person health and are core components of primary care. Oral health is an important part of this overall strategy. The intent of this standard is for PCPCHs to routinely screen or assess their patient population for oral health needs and facilitate referral, care coordination, and access to oral health services.

Relevant Definitions

***Dental Providers*:** Doctor of Dental Medicine (DMD), Doctor of Dental Surgery (DDS) or Expanded Practice Dental Hygienist (EPDH).

***Oral Health Assessment*:** An inspection performed to identify signs of oral or systemic disease, decay, malformation, or injury, and the potential need for referral for diagnosis and/or treatment.

***Oral Health Screening*:** A tool utilized to determine an individual's need to be seen by a dental provider.

Specifications for 3.F.1

A clinic is meeting measure 3.F.1 if it has a strategic process for conducting age-appropriate oral health screenings and/or risk assessments for its entire patient population. The strategy should include how oral health screenings results are documented.

Examples of age-specific oral health screenings and/or assessments:

Pediatrics:

- American Academy of Pediatrics/Bright Futures – Oral Health Risk Assessment Tool

Adults:

- Qualis Health - Rapid Oral Health Screening Risk Assessment
- American Dental Association - Caries Risk Assessment Form
- 1-2 Questionnaire Assessment that addresses:
    - Oral health history/ last time was seen by dental provider
    - Access to oral health services.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating how the clinic screens and/or assesses its entire patient population for oral health needs
2. The screening and/or risk assessment tools that the clinic utilizes for both adult and pediatric patients

Activities that do not meet 3.F.1:

- A family clinic has an oral health screening protocol for just children and pregnant patients but not for all adults. The clinic does not screen the entire patient population served at clinic.
- A clinic has a screening tool for pediatric patients and a risk assessment for adult patients, but cannot demonstrate a standard workflow for how these tools are used to screen its entire patient population.

Specifications for 3.F.2

A clinic is meeting measure 3.F.2 if it screens and/or assesses its entire patient population for oral health needs and has a strategy to identify and address the needs of priority patients with a positive oral health screening. Oral health priority populations could include patients who are at high-risk for tooth decay or oral diseases, tobacco users, children without access to fluoride, pregnant patients, patients with substance use or mental disorders, and patients with specific medical conditions such as heart disease, diabetes, or those who are immunocompromised. Age-appropriate interventions must be offered, tracked, and followed-up on for patients that have been identified as priority or at high risk for oral health care needs. The clinic is not required to deliver all oral health services itself but should have a process that facilitates patients' access to oral health services, including acting upon the results of any abnormal oral health screenings.

Examples:

- A clinic assesses all its patients for oral health needs and engages in active relationships with dental providers to ensure increased access to oral health for diabetic patients with

substance use disorder by coordinating care and sharing records in a more streamlined manner.

- A clinic screens all its patients for oral health needs, develops cooperative care relationships with oral health providers, and is able to follow up with these providers via routine communication exchanges to ensure better overall health for its patients with COPD.
- A clinic assesses all its patients for oral health needs and provides immunocompromised patients with guidance on accessing oral health services and follows up with patients regarding impact and barriers.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating how the clinic screens and/or assesses its entire patient population for oral health needs.
2. The screening and/or risk assessment tools that the clinic utilizes for both adult and pediatric patients

Activities that do not meet 3.F.2:

- A clinic does not screen and/or assess its entire patient population for oral health needs.
- A clinic tracks oral health resources via a spreadsheet daily, but it does not regularly follow-up on whether its patients were able to access those oral health resources.
- A clinic excludes certain segments of its patient population from receiving oral health services based on insurance coverage.

Additional Resources:

- Smiles for Life: A National Oral Health Curriculum (Society of Teachers of Family Medicine) provides resources on integrating oral health and primary care.
- Oral Health Toolkit (Health Management Associates, see Pages 8-10)

Specifications for 3.F.3

A clinic is meeting measure 3.F.3 if it has a comprehensive strategy for addressing oral health needs for its patient population which includes the following:

- ☑ A screening/assessment tool and criteria for providing oral health services to priority populations or those with high-risk oral health care needs.
- ☑ Oral health services provided by a dental provider at the clinic site and accessible to the entire patient population.

Examples of oral health services:

- Fluoride access
- Teeth Cleaning
- Caries treatment

- Preventive exam
- Dental Emergency Care
- Introduction/establishment to oral health home
- Collaborative practice agreements between oral health and primary care teams

Transformation in Practice

A clinic has integrated oral health services which are available to all its patients. It has a practice agreement with its dental providers to promote understanding between both entities on how to operate collaboratively. Depending on the results of an oral health questionnaire assessment, which is conducted at annual check-up appointments, patients are referred to the co-located dental clinic via a shared EHR system. By having the same front desk check-in for primary care and oral health appointments, the clinic proactively provides opportunities for patients to receive oral health evaluations, diagnoses, prevention and/or treatment of oral health diseases, disorders, and/or conditions.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating how the clinic screens and/or assesses its entire patient population for oral health needs
2. The screening and/or risk assessment tools that the clinic utilizes for both adult and pediatric patients
3. Evidence of oral health services provided onsite at the clinic (e.g., chart notes of both adult and pediatric patients)

Activities that do not meet 3.F.3:

- A clinic sponsors a mobile van that visits its location, but the services it offers are only available to those with specific health insurance coverage.
- The dental provider is not onsite at time oral health services are rendered.
- Patients are referred to the dental clinic but there are no collaborative efforts made between dental and primary care providers.

Standard 4.A – Personal Clinician Assignment and Continuity

This is a must-pass standard. Clinics must, at a minimum, meet measure 4.A.0 to qualify for PCPCH recognition.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

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.	**Must Pass**
4.A.2	PCPCH tracks and improves the percent of visits in which a patient saw their assigned clinician or team.	**10 points**
4.A.3	PCPCH meets a benchmark for the percent of visits in which a patient saw their assigned clinician or team.	**15 points**

Intent of Standard 4.A

Continuity of care is a core component of primary care and is associated with improved health care outcomes and patient experience. PCPCHs take steps to match their patients with the right provider or team for them and work to promote these relationships. By measuring how often patients receive care from their assigned provider or team, PCPCHs can improve continuity of care over time.

Relevant Definitions

***Active Patients*:** Patients who have had at least one office visit with any primary care clinician or team member at the clinic during a set time period prior to PCPCH application submission. This time period can vary by clinic but should between 12 months and 36 months.

Clinician: While used more broadly in other standards, "clinician" in this standard refers to a licensed physician, resident physician, physician assistant (PA) or nurse practitioner (NP) that provides primary care services.

***Team-based care model*:** A model of empanelment in which a "team" of providers collectively take responsibility for a set of patients and work together to provide their care. For the purposes of this standard, a "team" typically includes 2-4 primary care providers (MD, DO, ND, NP, PA). Teams may also incorporate other members such as a nurse care manager, medical assistant, front desk staff, behavioral health provider, or community health worker.

Specifications for 4.A.0

A clinic is meeting measure 4.A.0 if it is doing all of the following:

- ☑ Has a standard method for assigning or empaneling its patients to a personal clinician or team.
- ☑ Has a method of considering patient choice, need, or background in patient assignment to a personal clinician or team (examples may include respecting patient preferences for a specific provider or team, allowing patients to change their provider or team, or cultural and linguistic assignment of clinician). Clinics may not always have the ability to accommodate patients' preferences around specific providers or teams, but it's important that the clinic has a method of considering patient choice, need, or background at some stage (such as a process for allowing patients to change providers).
- ☑ Reports ***clinician or team assignment***: the percent of active patients that are assigned to a personal clinician or team. Clinics must use the formula and instructions in this guide to calculate this percentage and must report a numerator and denominator at the time of their online PCPCH attestation submission.
- ☑ Reports ***clinician or team continuity***: the percent of visits/appointments in which the patient saw their assigned clinician or team. Clinics must use the formula and instructions in this guide to calculate this percentage and must report a numerator and denominator at the time of their online PCPCH attestation submission.

Clinics that have implemented the team-based model of care can report assignment and continuity data based on patient visits with their assigned health care team. All other clinics must report data based on individual clinician assignment. If a clinic uses teams for its calculations instead of individual clinicians, then it must demonstrate that its patients are routinely informed of which team they are assigned to and what the team-based care model means for their care.

Clinics with a single clinician (solo practices) still need to submit data for this measure, even though they are assumed to have 100% assignment with a personal clinician.

Additional Tip

Cultural and linguistic assignment of clinician: PCPCHs can approach patient empanelment in a way that considers characteristics such as race, ethnicity, language, disability status, sex, gender identity, sexual orientation, age, social class, geographic region, life circumstances, religious or spiritual identity, values, or other sociological characteristics when matching patients with a clinician or team. Clinics may decide to focus on specific characteristics depending on their unique patient population and capacity, or encourage patients to self-identify the characteristics that mean the most for their care. Cultural and linguistic assignment may be incorporated into systematic empanelment methods or more individualized approaches such as leveraging traditional health workers during patient assignment.

Calculating Clinician or Team Assignment

Numerator: Number of active patients who are currently assigned to a personal clinician or team.

Denominator: All patients currently meeting the definition of active patient.

Sample Size: Clinics can choose one of the following two options for compiling data:

- Generate a report from an electronic system that includes all active patients at the clinic
- (If the clinic does not have an electronic system for compiling data) Conduct a random chart audit of at least 30 active patient records

Sampling Frequency: Clinics are expected to assess the percentage of patients with an assigned personal clinician or team at least once per year.

Examples:
Strategies to document assignment of a personal clinician:

- Using a standard field in an electronic medical record or practice management software.
- If using a chart audit, clear identification of the personal clinician or team on a patient's chart.

Sample calculation: A clinic has 3,428 active patients (which they define as patients that have had at least one office visit at the clinic in the last two years). Out of these 3,428 patients, 2,987 patients are assigned to a personal clinician or team.

4.A. Numerator = 2,987

4.A. Denominator = 3,428

% for clinician/team assignment = 87.14%

Calculating Clinician or Team Continuity

Numerator: Number of patient visits during the last 12 months in which the patient saw their assigned clinician or team

Denominator: Total number of patient visits during the last 12 months

Clinics should exclude visits with specialists and non-clinicians. If desired, clinics may also exclude visits with patients whose assigned PCP is at another clinic or location, walk-in clinic appointments, or urgent care clinic hours that are available to non-patients.

Sample Size: Clinics can choose one of the following two options for compiling data:

- Generate a report from an electronic system that includes the total number of patient visits/appointments at the clinic during the 12 months prior to PCPCH application submission.
- (If a clinic does not have an electronic system for compiling data) Conduct a random chart audit of at least 30 patient visits/appointments during the 12 months prior to PCPCH application submission.

Sampling Frequency – Clinics are expected to assess continuity of visits with the patients' clinician/ team at least once per year.

If you have questions about how to calculate your clinic's continuity data, please contact the program office at PCPCH@oha.oregon.gov.

Documentation required at a Verification Site Visit:

1. Data used to calculate clinician or team assignment
2. Data used to calculate clinician or team continuity

Activities that do not meet 4.A.0:

- There is no clinic-wide strategy in place to assign patients to clinicians or a team; assignment happens on an ad-hoc basis.
- There is no process for incorporating patient choice, need, or background into clinician assignment.
- A clinic calculates its data based on all of its primary care providers being on one "team" but does not inform their patients that they operate under a team-based model and what this means for their care.

Specifications for 4.A.2

A clinic is meeting measure 4.A.2 if it is meeting the requirements in 4.A.0 and has recently improved on the percent of visits/appointments in which patients saw their assigned clinician or team. What constitutes as "improvement" for a clinic will depend on its baseline performance and an improvement target that is unique to the clinic. Clinics must calculate their baseline, improvement target, and current performance using the steps below.

Step 1: *Calculate your current performance*
See instructions on pages 96-97 under "Calculating Clinician/Team Continuity." Clinics may use data from the last 6 months instead of the last 12 months if desired for this measure. For example, suppose Lady Bug Clinic is applying for PCPCH recognition in January of 2024. They can either calculate their current performance using the last 12 months (January – December 2023) or the last 6 months (July – December 2023).

Step 2: *Calculate your baseline performance*
The data used for this calculation will be from the 6 or 12 months directly preceding the measurement period used for your current performance. For example, if Lady Bug Clinic

calculated their current performance using data from the last year (January – December 2023) then they would use data from the year before (January – December 2022) to calculate their baseline performance. But if they calculated their current performance using data from the last 6 months (July – December 2023), then they would use data from the 6 months before (January – June 2023) to calculate their baseline.

Step 3: ***Calculate your unique improvement target*** using an 80% continuity benchmark and the formulas below.

First calculate "X" using the formula below:

$$\frac{80 - [\text{clinic baseline performance}]}{10} = \mathbf{X}$$

Then calculate your unique improvement target using the formula below:

[clinic baseline] + [x] = **Improvement Target**

For example, suppose Lady Bug Clinic is applying for PCPCH recognition in January of 2024 and wants to see if they improved their continuity in the last 6 months. They calculate their baseline continuity performance using 6 months of data between January and June of 2023 and find that patients saw their assigned clinician or team 56% of the time during that timeframe. They would calculate their improvement target as:

$$\frac{80 - 56}{10} = 2.4$$

$$56 + 2.4 = \mathbf{58.4\%}$$

Step 4: Compare improvement target to your current performance. If your clinic's current performance meets or surpasses your clinic's improvement target, you have successfully demonstrated improvement. For example, if Lady Bug Clinic calculates their current continuity performance using the 6 months of data between July and December of 2023 and finds that patients saw their assigned clinician or team 62% of the time during that timeframe, then they successfully demonstrated improvement since 62% is more than 58.4%

Documentation required at a Verification Site Visit:

1. Data used to calculate clinician or team assignment
2. Data used to calculate the clinic's current performance on clinician or team continuity (numerator, denominator, and resulting percentage)
3. The data used to calculate the clinic's baseline and improvement target; if the clinic has chosen to demonstrate improvement in the last 6 months, it will need to show 1 year of data. If the clinic has chosen to demonstrate improvement in last year, it will need to show 2 years of data.

Activities that do not meet 4.A.2:

- Clinic is unable to demonstrate that it has met its improvement target for continuity of clinician/team in the last year or 6 months.
- A clinic calculates its continuity data based on all of its primary care providers being on one "team" but has not informed their patients that they operate under a team-based model and what this means for their care.

Specifications for 4.A.3

A clinic is meeting measure 4.A.3 if it is meeting the requirements for 4.A.0 and can demonstrate that its patients saw their assigned clinician or team in 80% or more of patient visits/appointments during the last 12 months. See "Calculating Clinician/Team Continuity" on pages 96-97 for instructions on how to calculate your clinic's performance.

Example:

In the last 12 months, 3,428 unique patients had a total of 9,323 visits/appointments at a clinic. Out of these 9,323 visits, 7,010 visits were with the patients' assigned personal clinician or team.

4.A Numerator = 7,010
4.A Denominator = 9,323
% for 4.A = 88.01%

In this example, the clinic met the 80% benchmark for 4.A.3.

Documentation required at a Verification Site Visit:

1. Data used to calculate clinician or team assignment
2. Data used to calculate clinician or team continuity, which clearly indicates the names of the assigned providers or care teams and demonstrates that 80% or more of patient visits/appointments during the last 12 months were with the patient's assigned personal clinician or team

Activities that do not meet 4.A.3:

- A clinic is unable to demonstrate meeting the benchmark of 80% of patient visits with a patient's assigned personal clinician or team for the entire year preceding the PCPCH application submission date.
- A clinic calculates its continuity data based on all of its primary care providers being on one "team" but has not informed their patients that they operate under a team-based model and what this means for their care.

Standard 4.B – Medication Reconciliation and Management

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 25 pts):

4.B.2	PCPCH provides medication reconciliation for its patients.	**10 points**
4.B.3	PCPCH provides comprehensive medication management for its patients by a pharmacist.	**15 points**

Intent of Standard 4.B

There is evidence that significant health problems are caused, in part, by medication errors. Medication reconciliation and management can be important components of a comprehensive approach to preventing such errors. They are also critical components of care transitions for complex patients and effective primary care for patients with complex or high-risk medical concerns.

Relevant Definitions

Comprehensive medication management: The standard of care that ensures that patients' medications (i.e., prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. This is an encounter conducted face-to-face or via telephone between a patient and the pharmacist and is offered at least annually or more frequently following hospital or other facilities stays.

Medication reconciliation: The process of identifying the most accurate list of all medications that a patient is taking, including name, dosage, frequency, and route by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. A medical assistant, nurse or other care team member can initiate the medication reconciliation process with the patient, but a provider is required to review and assess medications based on the patient's current condition.

Patients with complex or high-risk medication concerns: Patients who are prescribed multiple medications, patients taking medications that have a narrow therapeutic index such as anticoagulants or psychiatric medications, patients experiencing transitions of care, or patients who are prescribed medications for chronic illnesses.

Specifications for 4.B.2

A clinic is meeting measure 4.B.2 if it provides medication reconciliation for all its patients or for its patients with complex or high-risk medication concerns. The clinic's medication reconciliation process must include all the following elements:

- ☑ The clinic's medical assistant (MA), nurse, provider, or other care team member identifies all medications a patient is currently taking (i.e., prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) including name, dosage, and frequency. The medication list should be developed by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.
- ☑ If the medication list was identified by a MA, nurse or other care team member, there is a process in place for communicating any medication changes to the provider for their review and assessment.
- ☑ The provider conducts a medication reconciliation by reviewing the medication list and any identified changes with the patient to assess any challenges in obtaining (refills needed, financial concerns) or taking the medication (side effects, timing etc.), assess appropriateness as a treatment based on the patients' current condition, assess the patient's understanding of how and why they are taking the medication, and ensure the medication list is updated appropriately.

Examples:

- A clinic instructs patients to bring all of the medications they are taking to their appointment, including any over-the counter or herbal medications, for the clinic's medical assistant to document into a medication list. The list is reviewed by the provider with the patient and family members as part of a patient visit to determine if any changes are needed.
- A patient is in clinic for a hospital discharge follow-up visit. The clinic's medical assistant has been trained by the provider on how to identify the most accurate list of medications a patient is currently taking at home and review the patient's discharge summary. If there are any changes in the patient's medications, the medical assistant notifies the provider. Then the provider has a conversation with the patient about changes to their prescriptions or other medications.
- Diabetic patients with an A1C of eight or above are deemed complex and are scheduled for a follow-up appointment every three months. A full medication reconciliation is conducted with the patient at these appointments, and this is discussed with the patient's provider.

Activities that do not meet 4.B.2:

- A medical assistant or other staff asks patients "Have you had any medication changes?" This question alone does not constitute a meaningful medication reconciliation.
- Patient or caregiver brings in a bag of medications or is asked to glance over their medication list without further discussion with a qualified healthcare provider.

- Changes to medication lists are not discussed with a provider.

Additional Resources:

Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation (Agency for Health Research and Quality)

Additional Tip

Health literacy and understanding

One of the strengths of the primary care home model is that care is coordinated and continuous. This approach can extend to the tracking and management of medications. PCPCHs can perform medication reconciliation for patients with complex or high-risk medication concerns at each of their visits, and especially after a hospitalization or other transition in care. Conducting medication reconciliations in a culturally and linguistically appropriate way, at an appropriate health literacy level, and in ways accessible by individuals with disabilities, as well as engaging the patient-defined and designated family members and caregivers as appropriate, will increase patient understanding and result in improved adherence and timely refills.

Specifications for 4.B.3

A clinic is meeting measure 4.B.3 if it has a pharmacist who works with the care team and performs the following types of functions for patients that the clinic has identified as having complex or high-risk medication concerns.

- ☑ Meets with patients, family, or caregivers to obtain and document a complete medication history.
- ☑ Reviews medical records and assesses patients' clinical status to ensure medications are appropriate, effective, and safe.
- ☑ Develops and implements a plan of care in partnership with patients and their care team.
- ☑ Plans follow-up evaluation and medication monitoring that includes assessment of patients' progress toward treatment goals.
- ☑ Is available for patient appointments and warm hand-offs when complex or high-risk medication concerns arise.

These services should be available for enough hours each week to adequately address the needs of the clinic's patient population. The pharmacist can provide services by telehealth if they meet all of the requirements listed above. A clinic cannot attest to this measure if the pharmacy services are only offered for provider consultations and the pharmacist does not meet with the patients.

Examples:

- A pharmacist collaborates with primary care providers and other care team members to improve the health of patients who are prescribed multiple medications. The pharmacist works to provide collaborative drug therapy management services, assist medical personnel and patients with drug information and identification, develop and sustain patient relationships, and evaluate and resolve identified drug therapy problems that are identified. They also work with patients to obtain information regarding drug use, drug allergies or sensitivities, and document this information in the patient's chart. Additionally, they are able to meet with patients either in person or by telehealth for appointments and are available for warm hand-offs when complex or high-risk medication concerns arise.
- A clinic is alerted that a patient has just been discharged from the nursing home following rehabilitation for a hip replacement and is returning to their home. The pharmacist reaches out to the patient and their caregiver to review their medications upon discharge and compare them to the medications they have at home and on the clinic's medication list prior to surgery. The pharmacist consults with the provider for refills of the patient's blood pressure medications and a new blood thinner, updates the clinic's EHR medication list, and adds that the patient has a new allergy to amoxicillin. The pharmacist also ensures that the patient is scheduled for a follow-up visit at the clinic.
- A clinic's pharmacist uses a risk stratification system to reach out and set up telehealth visits with each of the clinic's highest risk patients with diabetes at least once a year to review their medications and assess for effectiveness, safety, and adherence. The EHR medication list is adjusted, and the provider is engaged if appropriate.

Documentation required at a Verification Site Visit:

Chart note examples of comprehensive medication management plans. These must include the following elements and be developed in partnership with patients:

- Medication reconciliation during office visits and transitions of care
- Clear communication of desired clinical outcomes for each medication in use
- Monitoring of progress toward desired clinical outcomes
- Review and discussion of therapeutic goals with the patient and care team
- Planned follow-up intervals with the patient

Activities that do not meet 4.B.3:

- Care team members conduct medication reconciliation at an office visit but do not engage in proactive and coordinated medication management and do not involve a clinical pharmacist.
- A clinic utilizes a pharmacist who functions operationally in isolation from other members of the care team and lacks opportunities to collaborate with the care team and patients.
- A pharmacist is only available for in-person or phone consultations with the provider and does not meet directly with patients.

Standard 4.C – Organization of Clinical Information

This is a must-pass standard. Clinics must, at a minimum, meet measure 4.C.0 to qualify for PCPCH recognition.

Measures

Progressive – Select the level that best describes your practice (max 10 pts):

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.	**Must Pass**
4.C.1	PCPCH documents their patients' race, ethnicity, disability, sexual orientation, or gender identity in their electronic health record.	**5 points**
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.	**10 points** ***Health Equity Measure***

Intent of Standard 4.C

Implementation and use of electronic health record technology is essential for achieving many advanced primary care home functions such as improved population tracking, care coordination, communication, patient safety, and health equity. Maintaining comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as patients move throughout the health care system fosters safe transitions of care. Including select demographic characteristics in patients' EHR can help PCPCHs to provide high-quality care and services that are more specific to patients' background and health needs.

Relevant Definitions

***Active patients*:** Patients who have had at least one office visit with any primary care clinician or team member at the clinic during a set time period prior to PCPCH application submission. This time period can vary by clinic but should between 12 months and 36 months.

Certified Electronic Health Record: An electronic health record (EHR) that is certified through the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program.

Specifications for 4.C.0

A clinic is meeting measure 4.C.0 if it uses an ONC-certified electronic health record (EHR) which it updates as needed at each patient visit. The EHR must include the following elements:

- ☑ Standardized problem lists
- ☑ Medication lists
- ☑ Allergy lists
- ☑ Immunization records
- ☑ Basic demographic information (e.g., name, address, phone number, insurance information, patient-defined and designated family or caregivers authorized to access the patient's personal health information, and other contact information)
- ☑ Primary language and other communication needs (e.g., for individuals with disabilities)
- ☑ BMI/BMI percentile/growth chart as appropriate

These elements should be recorded in a consistent location in the EHR and the clinic should have a clear process for ensuring that they are regularly reviewed and updated by staff.

Note: Clinics with an EHR that is not certified by the ONC Health IT Certification program can email the PCPCH Program at pcpch@oha.oregon.gov for additional guidance and review.

Example:

A clinic uses an ONC-certified EHR and has a workflow to regularly review each patient's problem list, medication list, allergies, basic demographic information, primary language, BMI/BMI percentile/growth chart, and immunization record: a medical assistant reviews medications at each visit, front desk staff verify demographic and insurance information at check-in, an MA updates a growth chart at each well child visit, and nurse administered immunizations are documented on the immunization flow sheet. The clinic also asks all patients what name and gender pronoun they prefer and documents this information in the EHR.

Activities that do not meet 4.C.0:

- Documenting the above data elements in a paper chart.
- Using a non-certified EHR.

Specifications for 4.C.1

A clinic is meeting 4.C.1 if it is meeting the specifications for 4.C.0 and has a process for documenting one or more of the following patient characteristics in their electronic health records: race, ethnicity, disability, sexual orientation, or gender identity[23]. Clinics may either collect this information from patients directly, or partner with external organizations to obtain

[23] All PCPCHs must have a process for documenting their patients' primary language in their EHR (see specifications for must-pass measure 4.C.0). To meet 4.C.1, a clinic must also be documenting at least one of these additional listed categories.

this data about their patients. Clinics should ideally take steps to ensure that this information is collected, stored, transmitted, and accessed in a way that is patient-centered, trauma-informed, and considers the privacy and safety concerns of their unique patient population. Providing this information should be voluntary for patients.

Examples:

- A clinic collects and documents its patients' assigned sex at birth and gender identity in their EHR. To reduce data collection fatigue, the clinic partners with CCOs and private insurers to collect its patients' sex assigned at birth. It collects gender identity data directly during patient registration and as part of electronic check-in paperwork. To help promote trust and engagement, the clinic includes a brief introductory note for patients, families, and caregivers on the purpose for collecting this data and how it will be used, as well as it being completely voluntary.
- A clinic documents its patients' REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data in its EHR in accordance with the criteria and guidance provided by the OHA Equity and Inclusion Division.
- A pediatric clinic collects and stores information about its patients' disability status during new patient registration and/or check-in paperwork using pediatric-specific disability assessment criteria and EHR capabilities. The clinic ensures that its patients and families understand that providing this information is entirely voluntary.

Activities that do not meet 4.C.1:

A clinic has a section in their EHR designated for one or more of the patient characteristics described above, but does not have a process for regularly collecting or obtaining this information.

Additional resources around collecting demographic data:

- REALD & SOGI (OHA Equity and Inclusion Division)
- United States Interoperability Standards Advisory (ISA) offers standards around collecting and sharing data such as Patient Disability Status, Patient Tribal Affiliation, etc.

Specifications for 4.C.2

A clinic is meeting 4.C.2 if it is meeting the specifications for 4.C.0 and meeting a benchmark for the proportion of its patients that have one of the following characteristics documented in their electronic health record: race, ethnicity, language, disability, sexual orientation, or gender identity. Benchmarks are included in Table 4.C on the following page.

Table 4.C: Benchmarks for EHR documentation

Patient characteristic	Proportion of patients with this characteristic documented in their EHR
Race	80%
Ethnicity	80%
Language	80%
Disability	50%
Sexual Orientation	50%
Gender Identity	50%

Calculating Proportions:

Numerator: Number of active patients who have the select characteristic documented in their EHR.

Denominator: All patients currently meeting the definition of active patient.

Note: Clinics that distinguish between patients who have not yet provided demographic information for a specific category, and those who have indicated that they intentionally prefer not to provide information for that category, may exclude the latter from their calculations. Clinics that do not distinguish must include all active patients in the denominator, including those for whom their information is unknown.[24]

Example:

A clinic has 2,045 active patients, which it defines as any patient that had at least one visit in the last 24 months. Of these, 1,054 have their sexual orientation documented in their medical records (52%). They are therefore meeting the benchmark for documented sexual orientation (50%).

Documentation required at a Verification Site Visit:

Data used to calculate performance on benchmark

Activities that do not meet 4.C.2:

A clinic excludes all of their "unknowns" from their denominator. Clinics may exclude patients who intentionally prefer not to provide information for a particular category, but may not exclude other patients for which their status is unknown.

[24] There may be other reasons why a patient's status on a particular category is unknown that clinics can work towards improving (e.g. a patient has not yet been asked or did not fill out that section of their forms for unknown reasons that may include running out of time, not understanding the question properly, or not understanding the reason this information is being requested).

Additional Tips

Collecting demographic data

PCPCHs can consider the strategies below to ensure that they are collecting this data in a patient-centered way:

- To facilitate trust and engagement, provide patients with a brief background on why this information is being collected and how it will be used to improve the quality of their care or provide services that are more specific to their background and physical needs. Feel free to name a couple examples if helpful.
- Take steps to ensure that the type of data you are obtaining and method in which you are storing, transmitting, or accessing it acknowledges the safety and privacy concerns of your patients. Pediatric practices and those that serve adolescents, for example, may want to consider the risks in collecting SOGI data from children and teens.[25]
- To reduce form fatigue and build familiarity, consider integrating these questions into standard processes and workflows such as intake paperwork, check-ins (electronic or paper), and other forms of data collection that patients are already used to filling out.
- Consider which roles at the clinic are best equipped to collect this information. Trainings can be helpful as well as Traditional Health Workers (THWs) who are often already familiar with approaching care in culturally-responsive and trauma-informed ways.
- Consider how often patients need to be asked for specific information. Some of the demographic categories described in this standard may change over time, but clinics should consider minimizing the frequency at which they collect other information (e.g., race and ethnicity).
- Honor patient preferences around what types of information they want to share. For example, clinics may consider including in their EHR both a "declined" and "empty/unknown" option to distinguish between patients that have not yet provided this information for various reasons, and those who prefer not to answer and/or do not want to be asked again in the future.
- Review the "Additional Resources" section above for additional strategies.

[25] See the following journal article for important considerations and strategies around collecting SOGI data in pediatric settings: Goldhammer, et al. (2022). Pediatric sexual orientation and gender identity data collection in the electronic health record. *Journal of the American Medical Informatics Association*.

Standard 4.D – Clinical Information Exchange

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

4.D.2	PCPCH exchanges clinical information electronically to another provider or setting of care.	**10 points**
4.D.3	PCPCH shares clinical information electronically in real time with other providers and care entities through an electronic health information exchange.	**15 points**

Intent of Standard 4.D

Continuity of health care information during care transitions is important for patient safety and reducing unnecessary utilization of services. Advanced PCPCHs should not only maintain a comprehensive health record for each patient but also be able to send and receive electronic records to and from other health care providers, labs, hospitals, and pharmacies in real time to facilitate safe and effective transitions of care. The ability to have health information when and where it is needed is at the heart of this standard.

Relevant Definitions

Bi-directional: Moving or operating in two, usually opposite directions (e.g., being able to send and receive a patient's electronic health data).

Real-time exchange: An organized system to transmit data in real time between computer systems utilizing established message formats and standards. By using a real-time exchange, healthcare organizations, care providers, and patients can exchange electronic health data for more secure and efficient data processing. This data exchange does not require logging into a separate system.

Specifications for 4.D.2

A clinic is meeting measure 4.D.2 if it can demonstrate how important information in patient records is made available electronically to other health care providers – especially hospitals, emergency departments and frequently-used specialists. This information should include, but is

not limited to, demographic information,[26] problem lists, medication lists, allergies, laboratory and imaging, other diagnostic test results, and recent clinic notes. This can be done by logging in daily to another clinic's or hospital's system or portal in order to send or receive electronic information. Additionally, the clinic needs to participate in two of the following three electronic information exchange methods:

- A Centers for Medicare & Medicaid Services' (CMS) quality improvement program's health information exchange (HIE) objective (e.g., Merit-Based Incentive System (MIPS): Health Information Exchange Objective)
- Collective Medical, Epic Care Link or a similar bi-directional electronic communication
- One other electronic communication method such as eReferrals, EHR Direct Secure Messaging, EHR diagnostic imaging and/or lab result integration, or Immunization Registry (e.g., ALERT Immunization Information System)

Example:

- Every morning the clinic's care coordinator logs into the Collective Medical platform to review hospital and ED admissions and discharges from the day before. The clinic also has access to the local hospital's EHR through Epic Care Link and uses it to view and download relevant records for patients discharged from that hospital. The clinic also regularly uses eReferrals.
- A clinic has direct messaging set up in their EHR to send and receive patient records with external providers. Clinic staff log into the direct message system within their EHR, create a message that is relevant to the patient, and can coordinate with other external providers and facilities who use the same EHR and direct messaging system.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating daily log-in to another system for information exchange (documentation should include what system is being used and what type of information is being exchanged)
2. Evidence that the clinic participates in two of the three electronic information exchange methods outlined in the specifications above (e.g., screenshots or reports)

Activities that do not meet 4.D.2:

- A clinic does not have a protocol for daily log-in for data exchange. The clinic only exchanges data on an ad hoc basis.
- A clinic has secure faxing or e-faxing of patient records with other providers or care entities.
- A clinic is not meeting two of the three categories of electronic information exchange methods listed above.

[26] For example, it would be important for the clinic to share the language and communication needs of patients who speak languages in addition to English and/or with disabilities with other providers to ensure that those other providers are prepared to serve those patients via a bilingual provider, trained health care interpreter, and or assistive communications technologies.

Specifications for 4.D.3

A clinic is meeting measure 4.D.3 if it demonstrates that important information in patient records is available to other health care providers—especially hospitals, emergency departments, and frequently used specialists—in a real-time exchange. This information should include, but is not limited to, demographic information, problem lists, medication lists, allergies, laboratory and imaging, other diagnostic test results, and recent clinic notes. The clinic must also be able to receive important information in patient records that are available electronically from other care providers. These records must be sent bi-directionally in real-time and not require a separate log-in to another portal or system to send or receive documents.

Examples:

- A clinic participates in a health information exchange (HIE) via their EHR vendor (e.g., Carequality, Epic Care Everywhere, athenaClinicals, etc.) or a regional/community-based HIE integrated into their EHR interface (e.g., Reliance eHealth Collaborative).
- A clinic uses a shared EHR (e.g., EPIC) with emergency and specialty care providers.
- A clinic uses real-time Direct Secure Messaging or other HIE solutions to ensure providers have at least one option for information exchange with other external providers, care coordinators, and care team members regardless of the type of electronic health record system in use. The clinic demonstrates that multiple specialists and hospitals use the same HIE for direct messaging, send/receive messages in real-time without a separate log-in, and can access important information in patient records.

Documentation required at a Verification Site Visit:

Examples of clinic exchanging data bi-directionally with hospitals, ERs, and specialty providers in real time

Activities that do not meet 4.D.3:

- A clinic has a one-directional portal to see lab or imaging results in the local hospital EHR.
- A clinic participates in an immunization registry.
- A clinic has access to its local hospital's EHR to view and download patients' records, but it is not integrated with the clinic's EHR and requires a separate login.

Standard 4.E – Hospital Setting Transitions

This is a must-pass standard. Clinics must, at a minimum, meet measure 4.E.0 to qualify for PCPCH recognition.

Measures

4.E.0	PCPCH has a documented process for transitions of care with its usual hospital providers or directly provides routine hospital care.	**Must Pass**
4.E.2	PCPCH has a process for following up with its patients post-discharge from the hospital and emergency department.	**10 points**

Intent of Standard 4.E

Care coordination and communication during care transitions is an important aspect of patient safety, especially between inpatient and outpatient care settings. PCPCHs should take responsibility for facilitating appropriate transitions of care by developing relationships with their patients' usual providers of hospital care.

Relevant Definitions

Usual hospital providers: The hospital or hospitalist group that most frequently care for the clinic's patient population when admitted to a hospital or visiting the emergency room.

Specifications for 4.E.0

A clinic is meeting measure 4.E.0 if it has a documented process for transitions of care with its usual hospital providers. The documented process can take the form of a written agreement with its usual hospital providers or a written protocol, policy, or workflow describing transitions of care with these hospital providers. The following should be included in the documented process:

- ☑ The clinic's process for requesting hospital admission for patients
- ☑ Expectations for hospital communication with the clinic at the time of patients' hospital admission
- ☑ The clinic's process for sharing patient medical records at the time of hospital admission
- ☑ How the hospital communicates the patient discharge summary with the clinic at the time of hospital discharge

A clinic can also meet this measure by directly providing routine hospital care.

Examples:

- A clinic has written agreements with all the hospitals in the area in which its patients receive care, which include the elements above. This ensures that the clinic is notified when its patients are admitted and discharged from those hospitals so it can follow-up with patients to schedule needed appointments. The agreements also have a provision that ensures timely exchange of information between hospitals and their clinic.
- A clinic has a written policy and workflow for managing transitions of care with its local hospital. The clinic routinely reviews the policy and workflow to ensure that the processes remain relevant for its patient population and makes changes if needed.
- A clinic is part of a system which includes a hospital and there is written protocol and workflow for transitions of care with that hospital.
- Clinicians at a practice routinely provide hospital care directly to their patient population. The practice has a formal workflow or protocol for this hospital coverage which includes communication between specialists and primary care providers, sharing of patient medical records, and scheduling of post-discharge follow up appointments.

Specifications for 4.E.2

A clinic is meeting 4.E.2 if it has a documented policy, procedure or workflow for following up with its patients after they are discharged from the hospital or emergency department, which should include the following:

- ☑ How the clinic is notified when a patient is discharged from the hospital or emergency department.
- ☑ The clinic's outreach methods to the patient to coordinate and schedule follow-up appointments with their primary care provider, pharmacist, behavioral health consultant or other care providers.
- ☑ The clinic's performance expectations for scheduling after-discharge follow-up appointments.

Examples:

- As per their documented policy, a clinic devotes medical assistant staff time to conducting hospital follow-up calls with their patients and families within 3 days of a hospital discharge to schedule for follow-up with the patient's primary care provider and assess needs such help coordinating with other medical providers or procedures.
- A clinic's care manager nursing team is alerted by the hospital discharge planning team of an upcoming discharge to a skilled nursing facility to plan for the patient's needs including a follow-up appointment at the clinic, and to update the clinic's medical record with information regarding the transfer.
- A clinic has its clinical pharmacist outreach to its patients that were recently discharged from another facility such as a hospital or skilled nursing facility to review their medications to ensure the clinic has an up-to-date medication list, has reconciled any

changes in medication or dosages, and that the patient is taking them correctly and safely. The pharmacist also checks to make sure there is a follow-up visit scheduled with the patient's primary care provider and transfers the telephone call to the front desk for scheduling.

- A pediatric clinic receives a notification that three of its patients were seen in the ED the night before. The patients' care teams are notified as per the clinic's discharge workflow policy. They review the discharge notes in the electronic health system (or by requesting them from the hospital if not connected to the same system) and determine the need for a call to the family and/or to schedule a follow-up visit within the week.

Additional Tip

Ideally, post-discharge follow-up will be performed in a way that is culturally and linguistically appropriate and considers the health literacy needs of patients.

Activities that do not meet 4.E.2:

A clinic has a policy, protocol or workflow for transitions of care with its hospital providers but does not have a process for following up directly with patients or families after they are discharged.

Standard 4.F – Planning for Continuity

This is a must-pass standard. Clinics must, at a minimum, meet measure 4.F.0 to qualify for PCPCH recognition.

Measure

4.F.0	PCPCH has a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available.	**Must pass**

Intent of Standard 4.F.0

This standard is a functional step inherent in completing several other standards. It is essential that a clinic plans how they will respond to refill requests, clinical questions, and lab results during times when care team members are not available.

Specifications for 4.F.0

A clinic is meeting measure 4.F.0 if it tracks provider availability and assigns coverage for administrative requests, prescription refills, and clinical questions during a provider's absence. Staff should be able to describe the following:

- ☑ Explicit expectations for how the clinic covers providers and other care team members during their absence
- ☑ A process for notifying covering providers and team members of absences
- ☑ An explicit requirement that staff arrange coverage for absences of specific duration
- ☑ Contact information and method for all staff
- ☑ A process for staff to report unplanned absences from work
- ☑ Identification of the person responsible for tracking provider availability
- ☑ Identification of the person responsible for assigning coverage

Examples:

- Urgent patient requests are automatically routed to a covering provider when their team members are unavailable, and patients are notified if a non-urgent request won't be completed within a specified time frame.
- On-call providers are responsible for patient requests when team members are not available, and there is always a designated on-call provider available with interpreter services as needed.

- A team of medical assistants are responsible for in-basket coverage (i.e., daily work tasks) and know who is responsible for monitoring, in case of an absence.
- Locum providers are available to return phone calls regarding clinical questions from patients to their PCP.

Activities that do not meet 4.F.0:

- Patient requests are routinely postponed until their provider is back from vacation.
- Coverage is not designated to a specific person during times when team members are unavailable.
- The clinic has a written policy, but staff are unable to describe how coverage is provided to patients while their team members are unavailable.

Standard 5.A – Population Data Management

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 15 pts):

5.A.1	PCPCH uses data on its entire patient population to track overall health needs or engage in proactive patient population management.	**5 points**
5.A.2	PCPCH stratifies its entire patient population according to health risk.	**10 points**
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.	**15 points** ***Health Equity Measure***

Intent of Standard 5.A

In order to coordinate and manage care, a primary care home should be able to produce, track, and proactively utilize health-related information about its patient population. Clinics should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease, health care need, or health-related circumstances.

Definitions

Health-Related Social Needs (HRSN): Social barriers which affect people's ability to maintain their health and well-being. Examples include housing instability, housing quality, food insecurity, personal safety, lack of transportation and affordable utilities, etc.

***Risk stratification*:** This is the process of assigning a risk status to patients in order to segment a patient population into distinct groups of similar complexity and care needs, and then using this information to direct care and improve overall health outcomes. A clinic engaging in risk stratification must continually adjust their patients' risk levels and risk factors in accordance to changes in patients' conditions.

Specifications for 5.A.1

A clinic is meeting measure 5.A.1 if it generates, analyzes, and uses up-to-date data on its entire active patient population for patient management or tracking of a particular disease-state or

health care need. Patient management implies that a clinic actively monitors the health care needs of a sub-population of its patients and seeks to identify and correct "gaps" where indicated care has not been given.

Examples:

- A clinic maintains an active searchable registry of patients with a specific condition (e.g., diabetes, pregnancy). Registries can sometimes be integrated in the EHR, but clinics can also use a simple tracking system, such as Microsoft Excel.
- A clinic uses a list of patients to generate patient reminder outreach for indicated care (e.g., lab tests, imaging, well-child appointments, immunizations).
- A clinic maintains a registry of patients with diabetes or asthma and tracks the percentage of patients that are up to date on indicated care and testing (e.g., hemoglobin A1c, consistently taking appropriate medications).
- A clinic keeps a registry of pregnant patients and follows up with those who miss appointments for prenatal care.
- A clinic generates an inclusive list of patients in the clinic who have a particular health behavior to target health promotion activities (e.g., smoking, obesity, hypertension, uncontrolled diabetes) or need for follow-up.

Documentation required at a Verification Site Visit:

Patient lists generated by the clinic that are used to track and proactively manage patients with specific conditions or health care needs (e.g., mammograms, well-child appointments, HbA1c)

Activities that do not meet 5.A.1:

- The clinic has the capability to generate a list of patients in the clinic who have a particular diagnosis (e.g., diabetes, hypertension) or health behavior (e.g., smoking, obesity, high blood pressure, uncontrolled diabetes), but it does not regularly use this capability.
- A clinic generates a population-based list quarterly but does not routinely use this data for the purposes of patient management or tracking of the particular disease-state or health care needs/interventions.
- Data reports that are used to manage a particular health condition are generated from a payer or third party, and do not include the clinic's entire patient population.

Additional Resources:

- Using a Simple Patient Registry to Improve Your Chronic Disease Care (2006) (Family Practice Management Journal, Oritz)
- Registries Made Simple (2011) (Family Practice Management Journal, Bagley & Mitchell)

Specifications for 5.A.2

A clinic is meeting measure 5.A.2 if it implements and uses an risk stratification process on its entire active patient population to identify patients who are at higher risk for developing poor health outcomes. It is critical that the risk stratification process involves all patients of all ages who receive primary care in the clinic. The clinic must be able to describe its process for regularly reviewing the risk stratification assignments for its patient population and adjusting risk scores accordingly.

Examples:

- The clinic implements a risk stratification strategy for its patient population based upon disease states, psychosocial risks, and special healthcare needs (e.g., children with special healthcare needs) to most effectively target interventions, care coordination, and care planning resources for their patients.
- The clinic utilizes a tool or process to stratify their patient population based upon health risk and can provide lists of patients and their risk assignment.
- The clinic collaborates with an independent physician association (IPA) or other organization to assign risk stratification to its entire patient population and can produce lists of patients and their risk assignments. These lists are not limited to subsets of patients at the clinic and are updated by the clinic as needed.

Additional Tip

Racial biases in data collection

Research has shown a racial bias in popular risk stratification algorithms,[27] [28]especially when using health costs as a proxy for health needs. While there are no perfect or quick fixes for systemic inequities or large-scale algorithm development and implementation, PCPCHs can make efforts at a clinic- and provider- level to reduce implicit bias and the resulting health disparities. The resources below outline some possible approaches.

- Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here? (The Permanente Journal - 2011)
- How to Reduce Implicit Bias (Institute for Healthcare Improvement – 2020)

Documentation required at a Verification Site Visit:

1. Description of the criteria used to determine each level of risk
2. De-identified lists, registries, or trackers demonstrating how the clinic is tracking patients who meet the criteria for selected risk stratification categories

[27] Ledford, H. (2019). Millions of Black people affected by racial bias in health-care algorithms. *Nature*.

[28] Gianfrancesco, M. et al. (2018). Potential Biases in Machine Learning Algorithms Using Electronic Health Record Data. *JAMA Internal Medicine,* 178 (11): 1544-1547.

Activities that do not meet 5.A.2:

- The clinic has performed a risk stratification process, but only for a subset of its patient population.
- The clinic has performed a risk stratification process but does not periodically review and adjust risk scores accordingly.
- The clinic has an automated risk stratification process built into their EHR and patients are automatically assigned a risk score, but clinic staff are not aware of what the score means, or how it is utilized for patient care within the clinic.

Additional Resources:

- Population Health Management-Risk Stratification (National Association of Community Health center's Action Guide)
- Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients (American Academy of Family Physicians)
- Risk-Stratified Care Management and Coordination Matrix (American Academy of Family Physicians)
- Children with Health Complexity (Oregon Pediatric Improvement Partnership)

Specifications for 5.A.3

A clinic is meeting 5.A.3 if it is meeting the specifications for 5.A.2 and incorporates at least one health-related social need or demographic category into its risk stratification system. Demographic categories may be defined by characteristics such as race, ethnicity, language, disability status, gender, gender identity, sexual orientation, age, social class, geographic region, life circumstances, or other characteristics relevant to the clinic's patient population.[29]

Examples:

- The clinic implements a risk stratification strategy for its patient population based upon disease states, psychosocial risks, special healthcare needs *and language* to target interventions, care coordination, and care planning resources most effectively for their patients.
- A clinic with a significant homeless population stratifies its entire patient population according to health risk and housing instability status to ensure that care strategies consider this need. For example, many patients experiencing housing instability have a higher risk score than comparable patients without housing instability.
- Every patient at a clinic is assigned two risk scores – one related to their disease state, psychosocial risks and special healthcare needs and one related to their health-related social needs. Clinic staff are able to see both scores when providing and planning care.

[29] See *PCPCH Standard 4.C – Organization of Clinical Information* for guidance around collecting demographic data from patients in a trauma-informed and trust-building way.

Documentation required at a Verification Site Visit:

1. Description of the criteria used to determine each level of risk (must include both health risk and at least one HRSN or demographic category)
2. De-identified lists, registries, or trackers demonstrating how the clinic is tracking patients who meet the criteria for selected risk stratification categories

Activities that do not meet 5.A.3:

- A clinic has a risk scoring system for patients, but the system does not consider at least one health-related social need or demographic category.
- A clinic assigns risk scores to patients based on one or more health-related social needs but does not incorporate health risks such as disease state, psychosocial risks, or special healthcare needs into their overall risk stratification strategy.

Standard 5.B – Health Care Cost Navigation

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 20 pts):

5.B.1	PCPCH informs their patients of preventive services that do not require cost-sharing.	**5 points**
5.B.3	PCPCH assists its patients in navigating the cost and payment options for their care.	**15 points** ***Health Equity Measure***

Intent of Standard 5.B

Cost of care can serve as a barrier to patients receiving primary care, adhering to recommended treatments, and establishing a trusting relationship with their medical home. State and National assessments have found that many patients delay or go without medical care due to cost concerns or uncertainty, with the proportion being higher among specific ethnic groups, geriatric populations, those who are low-income, and other groups.[30] [31] [32] PCPCHs can reduce these barriers by increasing transparency with regards to the cost of visits, services, treatments, and medications and assisting their patients in navigating their payment options.

Specifications for 5.B.1

A clinic is meeting 5.B.1 if it provides patients with information about its most commonly-offered preventive services that typically have low or no out-of-pocket costs with insurance (i.e., services with low or no copayments, coinsurance, or which don't require deductibles). Clinics may include this information during patient registration, as part of preventive service reminders, welcome packets, webpages, appointments, scheduling processes, or other avenues that can reduce cost concerns that patients may have in scheduling or following through with preventive services.

Ideally, clinics should strive to promote this information in a variety of ways to account for patients with health literacy barriers, those with primary languages other than English, and those generally unfamiliar with the healthcare payment system. When relevant, communications about cost should clarify which services are considered part of the preventive appointment and

[30] Ortaliza et al. (January 2022). How does cost affect access to care? *Kaiser Permanente*.
[31] Montero et al. (July 2022) Americans' Challenges with Health Care Costs. *Kaiser Family Foundation*.
[32] Oregon Health Authority (April 2022). Impact of Health Care Costs on People in Oregon, 2019. Page 19.

which may require additional cost-sharing (e.g., subsequent tests, follow-up appointments, referrals, or specific diagnoses). Patients should also be directed to confirm co-pays or out-of-pocket costs with their personal insurance plans, to reduce false expectations or surprise bills.

Examples:

- After assessing its payer mix, a clinic includes in its patient welcome packet and on its website information about the preventive services it offers that are typically free under OHP, Medicare, and the private plans that its patients use, along with a disclaimer for patients to confirm with their individual plan. The clinic includes this information in both English and Spanish due to the proportion of its patients with Spanish as their primary language.
- A clinic incorporates cost-sharing information into its automated service reminders for each of its most common preventive services. For example, when sending out reminders to patients over 50 that are due for breast cancer screenings, the clinic includes in these communications a reminder that these services are fully covered for this age group by most public and private health insurance plans, along with a disclaimer to confirm with their payer.
- A clinic provides its scheduling team and patient navigators with an up-to-date list of its internal preventive services that typically do not require a co-pay or deductible. These staff are trained to share this information with patients to encourage follow-through, to clarify which services are considered as belonging to the preventive care bucket and which may require cost sharing, and to direct patients to contact their own plan for confirmation.

Documentation required at a Verification Site Visit:

Evidence of clinic informing patients of their most commonly-offered preventive services that are free or low-cost with standard insurance (e.g., screenshots, examples, communication materials, evidence of workflow, etc.)

Activities that do not meet 5.B.1:

- A clinic provides its patients with a bill or cost breakdown after services are rendered, but does not promote low-cost or free preventive services beforehand.
- A clinic informs its patients of the free or low out-of-pocket costs for just a few of its preventive services or on an adhoc basis, but has not developed a process around its most commonly-offered applicable services.

Additional Resources:

- Preventive care benefits for adults (Healthcare.gov)
- Preventive care benefits for women (Healthcare.gov)
- Preventive care benefits for children (Healthcare.gov)
- Oregon Individual Market Insurance Plan Comparison (Division of Financial Regulation)
- Medicare Costs and Medicare Coverage Search (Medicare.gov)
- Oregon Health Plan Benefits (Oregon.gov)

Specifications for 5.B.3

A clinic is meeting 5.B.3 if it provides one or more of the following cost coordination services for its patients:[33]

General Cost Navigation Services:

- ☐ Provides price transparency or generalized out-of-pocket cost estimates for services provided at the clinic.
- ☐ Provides price transparency or generalized out-of-pocket cost estimates for other services relevant to patient care (e.g., prescriptions, tests, labs, etc.).
- ☐ Maintains an updated list of contacts or resources that patients can reach out to with questions about what their specific insurance plan covers (e.g., phone numbers, cost-estimator web tools, etc.) and promotes these resources ahead of patient care.
- ☐ Provides patients with diagnosis codes and CPT codes or official names of internal services that they can use to acquire cost estimates.
- ☐ Works with external specialists to obtain CPT codes for frequently-used external services, tests, and/or labs and shares this information with referred patients.
- ☐ Informs patients of less expensive care options (e.g., prescriptions, tests, treatments, etc.) when appropriate and/or informs patients of which services or treatments should be prioritized in the event of limited funds.

Individual Insurance Plan Navigation Services:

- ☐ Provides patients with estimates of how much a visit, service, test, or treatment at the clinic will cost them based on their specific health plan (i.e., how much will likely be paid by their insurance vs out-of-pocket).
- ☐ Provides individual patients with estimates of how much a prescribed medication will cost them specifically based on their plan.
- ☐ For frequently-used external services, provides individual patients with estimates of how much an external service (e.g., referral, ordered test, lab work) will cost them specifically based on their plan.
- ☐ Coordinates or connects individual patients with healthcare payment resources (e.g., Oregon Health Plan, Children's Health Insurance Program, healthcare.gov, co-pay and deductible assistance programs, prescription cost assistance programs, etc.), healthcare navigation resources (e.g., CBOs that assist with healthcare system navigation) or to health care programs, clinics, events, or organizations that provide free or low-cost care.

[33] **Note:** While PCPCH Measure 5.B.1 focuses only on *preventive* services offered by the clinic, PCPCH Measure 5.B.3 encompasses a broader range of healthcare services, test, treatments, procedures, etc.

Clinics may provide these cost navigation services directly (via care coordinators, patient navigators, traditional health workers, etc.) or partner with external entities such as payers, community-based organizations, contractors, or other organizations. Clinics may choose to offer these services to all relevant patients or target specific patient subgroups based on financial need or other barriers to health care cost navigation (e.g., patients who are low-income, experience low health literacy, speak primary languages other than English, who are uninsured, underinsured, etc.). Clinics must ensure that patients are made aware that these services or resources are available to them (e.g., during patient orientation or welcome packets, on website, posters, as part of workflows, etc.).

Documentation required at a Verification Site Visit:

Evidence demonstrating the type(s) of cost navigation services provided (e.g., written policy or procedures, workflow, EHR tool, webpage, poster, patient materials, or evidence of other communication channels)

Activities that do not meet 5.B.3:

- A clinic provides cost transparency or itemized billing after services have been rendered but does not assist its patients in understanding their out-of-pocket costs before receiving care in at least one of the ways described on page 124.
- A clinic provides health care cost navigation for only a few specific conditions or services instead of providing more general cost navigation services.

Health Care Cost Coordination Resources:

- Oregon Individual Market Insurance Plan Comparison (Division of Financial Regulation)
- Medicare Fee Schedules and Cost-Sharing Resources:
  - CMS Physician Fee Schedule
  - Medicare Costs
- Oregon Health Plan Fee Schedules and Cost-Sharing Resources:
  - OHP Fee-for-Service Fee Schedule
  - Oregon Health Plan Benefits
- Many private payers also have help lines or cost-estimator tools available. See Health Plan Transparency Guidelines (CMS.gov).

Standard 5.C – Complex Care Coordination

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 30 pts):

5.C.1	PCPCH assigns care coordination responsibilities to specific clinic staff and informs patients, families, and caregivers on how to access care coordination services.	**5 points**
5.C.2	PCPCH identifies patients with complex care needs and coordinates their care.	**10 points**
5.C.3	PCPCH collaborates with diverse patients, families, or caregivers to develop individualized and culturally appropriate written care plans for complex medical or social concerns.	**15 points**

Intent of Standard 5.C

Care coordination is an essential feature of a primary care home. The intent of this standard is to ensure that PCPCHs deliberately consider care coordination functions, explicitly assign these functions to specific staff members, take extra steps to coordinate the care of diverse patients with complex care needs, and communicate clearly to patients, families, and caregivers about how they can access care coordination services. This standard also promotes the development of individualized care plans for diverse patients with complex medical and social needs to help coordinate and integrate their care. Identifying patients with higher health risks, implementing a strategy to help those most in need, and effectively coordinating and managing care for higher risk sub-populations can help prevent exacerbations of illness and other health complications.

Relevant Definitions

Care coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care, in order to facilitate the appropriate delivery of health care services. Organizing care involves investment in personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Care plan/planning: The process by which health care professionals and patients discuss, agree upon, and review an action plan to achieve the goals or behavior change of greatest relevance and concern to the patient. A care plan is the written document recording the process

and outcomes of the care planning journey. Care plans should be personalized and incorporate the patient's unique circumstances and personal goals.

Culturally and linguistically appropriate care (also called "culturally competent care"): A manner of delivering health care services that is respectful of and responsive to the cultural and linguistic needs of all individuals by considering characteristics such as race, ethnicity, language, disability status, sex, gender identity, sexual orientation, age, social class, geographic region, life circumstances, religious or spiritual identity, values, or other sociological characteristics.

Specifications for 5.C.1

A clinic is meeting measure 5.C.1 if it has a person(s) or team responsible for care coordination, a written description of their role/functions, and a method for notifying patients, families, or caregivers of who is responsible for coordinating their care and/or how to reach the correct staff.

To meet this measure, a clinic must illustrate clear assignment of care coordination responsibilities to clinic staff and clear communication to patients, families, and caregivers about how to obtain these services. Care coordination functions within the clinic do not need to be assigned to one single person. Some care coordination activities may be performed by clinical staff (e.g., motivational interviewing, support of behavior change, patient-specific education) while others may be performed by non-clinical staff (e.g., follow-up on referrals and test results). However, patients, families, and caregivers should be informed on how to contact the right staff for specific needs related to care coordination, and the functions on the team related to care coordination must be clearly defined in writing for each relevant team member.

Additional Tip

Care coordination functions

Below are examples of care coordination functions that should be considered when developing roles within the care team:

- Provision of separate visits and care coordination interactions
- Managing and tracking tests and referrals
- Coaching patients, families, and caregivers
- Facilitating transitions of care
- Use of health information technology
- Continuous management of communications internally and externally for the care team and patients
- Development of care plans in collaboration with patients, families, and caregivers
- Completion and analysis of patient assessments
- Integration of critical care information

Activities that do not meet 5.C.1:

- Unclear assignment(s) of care coordination responsibilities.
- Lack of clarity or information on whom patients should contact for specific care coordination needs.

Specifications for 5.C.2

A clinic is meeting measure 5.C.2 if it can describe its criteria for identifying diverse patients with complex care needs as well as the activities performed by staff to assist with targeted care coordination for these patients. These staff must have received specific training on these activities, such as providing patient-specific education, tracking referrals, or supporting behavior change (e.g., diabetic education or training in preventing adverse events related to polypharmacy). A clinic must have a strategy or process that tracks which patients are receiving care coordination for complex care needs.

Examples of groups of diverse patients with complex health care needs include children with special health care needs, adults or children with certain chronic diseases/needs or multiple chronic diseases, individuals taking multiple medications, individuals seeing several specialists, individuals with multiple recent hospitalizations, or any other complex medical or social need that place patients at a higher risk for health complications. Strategies for identifying these patients might include EHR reports, risk stratification scores, ED reports, etc.

Example:

A clinic has a written policy that specifies which types of diagnoses and health risk conditions will identify patients as having complex care needs and warrant care coordination. These patients receive additional coordination services such as extended self-management support, personal introductions to care team members, and tracking of referrals to external providers or community-based organizations. The written policy also specifies which staff roles are responsible for coordination of these services.

Documentation required at a Verification Site Visit:

1. Written policy, procedure, or workflow that includes the criteria the clinic uses to identify diverse patients with “complex health care needs” that would benefit from additional care coordination
2. Evidence that clinic is tracking which patients are receiving care coordination for those complex health care needs
3. Written demonstration of the activities performed by clinic staff to assist with care coordination for diverse individuals with complex health care needs

Activities that do not meet 5.C.2:

A clinic identifies opportunities for complex care coordination on a case-by-case basis, based on provider discretion or an unofficial/undocumented process.

Specifications for 5.C.3

A clinic is meeting measure 5.C.3 if it collaborates with its identified complex patients to develop and implement whole-person, culturally and linguistically appropriate, personalized, written complex care plans. The care plans should include, at a minimum:

- ☑ Patient-specific short-term and long-term health goals
- ☑ The action plan for achieving these goals or managing the patient's condition
- ☑ Three elements from across the two lists on pages 129-130 (primary and supportive services) that the clinic has determined to be most impactful to individual patients and their overall treatment/ management plan

Care plans should be developed collaboratively with each patient or patient's family and/or caregivers and be reviewed with them before finalizing. Care plans are not required for every patient in the clinic, rather those with the most complex needs and medical and/or social concerns.

The care plan should be written at an appropriate health literacy level, accessible by individuals with disabilities, documented in the medical record, and updated regularly. The clinic should also ensure that non-English speaking patients are able to understand and reference the care plan whether that be by translating the written care plan or ensuring that an interpreter (or caregiver/family member if preferred)[34] reviews it with the patient.

Further, the development and use of a patient-centered complex care plan requires the ongoing participation of multiple members of the care team. Note that care planning happens over time and is not a "one and done" approach to patient care. Every professional at the clinic who plays an integral part of the patient's care should be familiar with and have access to the patient's care plan. Ideally, external providers involved in the patient's care would also be familiar with the care plan.

The care plan format should fit into the care team's workflow and should be delivered to the patient in their preferred format (e.g., hard copy, e-portal, mail). All clinic staff should be aware of this workflow and be able to identify the roles at the clinic involved in this process. Finally, if a patient does not consent to a care plan when offered, this should be documented in the patient's chart.

Primary Elements

The elements most commonly found in care plans:

- Patient-specific education regarding conditions and treatment(s)
- Self-management of chronic conditions (a contingency plan for exacerbations, such as asthma care plan, diabetes, CHF)
- Names and roles of community-based support or services outside the clinic
- Behavioral health or substance use disorder treatment(s)
- Barriers to care and potential solutions

[34] See PCPCH Standard 6.A.0 for expectations around interpretation services.

- Psychosocial concerns and coordination of health-related social needs
- Coordination with sub-specialists

Supportive Services Elements

Often applied in pediatric practices and used to support patient self-identified goals and/or interventions:

- Equipment (e.g., tracheostomies, gastronomy tubes, wheelchair, orthotics)
- Appliance/Assistive technology (e.g., nebulizers, wheelchairs, orthotics, walkers)
- Therapies (e.g., speech, physical therapy, occupational therapy)
- Individualized Education Program (IEP)
- Individual Family Service Plan, 504[35]
- Home care/nursing services
- Developmentally Disabled (DD) Waiver

Example:

A pediatric clinic collaborates with its identified complex patients and their parents/caretakers to create personal and unique care plans for them. This becomes an essential focal point in their charts and is incorporated in their EHR system. The care plan is managed by the medical home but is informed by the guidance counselors at the local elementary schools or anyone else involved in the care of the child. Each care plan includes (1) patient-specific short-term and long-term health goals, (2) the action plan for achieving them, (3) patient-specific education regarding conditions and treatments, (4) self-management of chronic conditions, and (5) names and roles of community-based support outside the clinic. The entire and continual care plan process includes:

- Assessing which child needs a care plan
- Ensuring the family is central to creation of the care plan
- Ensuring the care plan is maintained, updated, and shared with appropriate members of the care team, specialists, and community partners

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow demonstrating how care plans are utilized throughout the clinic, including the distribution process
2. Demonstration that the care plans include patient-specific short-term and long-term health goals, the action plan for achieving these goals or managing the patient's condition, and at least 3 "care plan elements" from across the primary and supportive services lists

Activities that do not meet 5.C.3

- A clinic copy-pastes the provider's general assessment from a patient's chart notes into their After-Visit Summary in place of creating an individualized patient care plan.

[35] Stuart, A. IFSP: What It Is and How It Works. *www.understood.org*.

- A clinic develops care plans but less than 3 of the primary or supportive elements described above are included.
- A clinic develops a care plan for each patient instead of collaborating with the patient and/or family or caregivers to develop personal goals.

Additional Resources:

- PCPCH Care Planning Toolkit and PCPCH Resources and Technical Assistance webpage includes additional resources and care plan templates
- Develop a Shared Care Plan (Agency for Healthcare Research and Quality)

Additional Tip

SMARTIE goals

The ideal care plan will establish a shared understanding of what is important to the individual patient, how goals can be met, and how to know if goals have been met. SMARTIE is a framework that clinics can use to ensure that both a patient and their care team understand their overall goal, and to develop a plan to address barriers or identify interventions to meet that goal. Below is an example of how to write a SMARTIE goal:

Specific: State the goal clearly. If the goal is "I just want to stay healthy," ask what that means. For one person, it might mean staying out of the hospital; for another, it might mean being able to walk a certain distance three days a week.

Measurable: Identify and quantify the observable markers of progress, such as pain levels or number of days walked each week.

Attainable: Break the goal into smaller, actionable steps. Identify expected barriers and make a plan to address them.

Relevant: Make sure the goal reflects what's important to the individual. Motivational interviewing can be used to tie clinical goals, such as blood pressure control, to the goal of staying healthy.

Time-Bound: Define the period in which the goal is to be attained. Agree on when to check for progress.

Inclusive: Make sure the goal considers the patients' background, culture, traditions, or other values related to their health, as well as the input of others who are involved with the patients' care or life circumstances (e.g., parents, family, caretakers, etc.).

Equitable: Make sure the goal is fair and considers the various barriers that the patient may face in achieving good health as a result of systemic inequities.

Check out the PCPCH Care Planning Toolkit for more tools, strategies, and templates.

Standard 5.D – Test and Result Tracking

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measure

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.	**5 points**

Intent of Standard 5.D

Test tracking is an important aspect of care coordination. The intent of this standard is for PCPCHs to actively track ordered tests, ensure that patients, caregivers, families, and clinicians are adequately informed of test results, and work to ensure completion of tests that have been ordered.

Specifications for 5.D.1

A clinic is meeting measure 5.D.1 if it is doing all of the following:

- ☑ Systematically tracks ordered tests, imaging, and procedures for its entire patient population. The tracking system includes whether results have been received and were communicated to the ordering clinician and to the patient, family, and/or caregivers in a timely manner.
- ☑ Ensures that tests are completed. If patients are unable to complete the test, this should be reflected in the medical record and/or test tracking systems.
- ☑ Ensures that patients, families and/or caregivers understand what the results mean, including whether the test result is normal or abnormal for the patient and information on follow-up and/or the next testing interval.

Example:

A clinic uses their EHR to track tests that are ordered (e.g., laboratory tests, imaging). The EHR tracks when test results have been received by the clinic and whether the patient and ordering clinician have been informed of the test results. The clinic explains the results to patients, families, and/or caregivers and documents this in the medical record. To ensure completion of ordered tests, the clinic has a workflow to run a report in the EHR every 30 days for staff to follow up on tests that have been ordered but have not been completed by the patient.

Additional Tip

Clinics can take steps to ensure that patients with diverse backgrounds and circumstances are able to understand their test results by communicating them in a way that considers patients' health literacy level, primary languages, and disabilities.

Documentation required at a Verification Site Visit:

Policy, procedure, or workflow that includes:

- How the clinic tracks test results including test status, result status and confirmation that results were communicated to the ordering clinician and to the patient, family, and/or caregivers
- How clinic follows up with patients who have had tests ordered but have not completed them

Activities that do not meet 5.D.1:

- A clinic relies on external entities (lab or radiology department) to notify patients of test results and cannot determine, using its own systems, if patients have been notified of their results.
- A clinic does not follow up on open or expired orders; it only tracks test results when they are received and cannot determine if a test has been ordered but not performed.
- A clinic conveys results to patients, families, or caregivers but does not take steps to ensure that the patient understands them. For example, they provide results without explaining what they mean, the implications of the results, and/or why this may or may not affect their treatment.

Standard 5.E – Referral and Care Coordination with Specialists, Care Facilities and Government Systems

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 30 pts):

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.	**5 points**
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.	**10 points**
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.	**15 points**

Intent of Standard 5.E

PCPCHs are a critical partner in coordinating patient care outside of the clinic. Clinics should strive to connect patients with care that is delivered in other care settings and coordinate services with diverse community providers. In addition to improving patient safety and reducing medication errors, this type of care coordination improves patient empowerment, experience, and understanding of their health. The intent of this standard is for PCPCHs to take responsibility for coordinating care offered outside of their clinic walls.

Relevant Definitions

Coordination of care: Meaningful communication and cooperation among health professionals which allows patients and/or caregivers to more easily access and navigate various care settings and services.

Long-term care facility: A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals.

Referral follow-up: A clinic engages in referral follow-up if it systematically contacts patients and/or the external organizations/specialists to determine whether the patient followed through with a referral or what the barriers are for patients not completing a referral.

***Referral tracking*:** A clinic engages in referral tracking (sometimes referred to as "closed-loop referrals") if it keeps a record of referrals, referral follow-up, and referral statuses. The following information should be documented:

- Referral information (i.e., service, specialist, organization)
- The results of follow-up activities (i.e., whether contact was achieved, barriers that prevented patients from completing a referral, and any attempts to address those barriers)
- The final outcome of the referral (i.e., whether patients received the app. or service)

Specifications for 5.E.1

A clinic is meeting measure 5.E.1 if it has a system for tracking external specialty referrals. In addition to general referral information, the referral tracking system must include the status of the referral, whether a consultation report has been received by the clinic, and whether the outcome(s) of the consultation have been communicated with the patient, families, and/or caregivers. The tracking system should also include the outcome of any follow-up with patients or specialists regarding referrals. Clinics are encouraged to consider culturally and linguistically appropriate specialists, specialized settings, and community services providers when referring their patients.

Examples:

- A clinic uses a paper log tracking system for specialty referrals which clearly identifies referral status, whether a consultation report has been received, and whether patients, families, and/or caregivers have received the external providers' recommendations.
- A clinic uses an electronic system to track referrals to external providers which clearly identifies referral status, whether a consultation report has been received, and whether patients, families, and/or caregivers have received results. This electronic system can be within the clinic's EHR or independent of it.

Documentation required at a Verification Site Visit:

1. Policy, procedure, or workflow for tracking referrals to specialty providers which includes the components described above
2. The referral log or referral tracking system with examples of individual referral notes

Activities that do not meet 5.E.1:

- The clinic only tracks a subset of referrals to consulting specialty providers.
- The clinic does not track referrals to completion as they do not track follow-up with patients, families, and/or caregivers.

Specifications for 5.E.2

A clinic is meeting measure 5.E.2 if it is actively involved and coordinates patient care when patients are receiving care in one or more of the following specialized settings: hospitals, in-patient behavioral health facilities, Skilled Nursing Facilities (SNF), and/or long-term care facilities. Coordination must include some form of two-way communication with either the specialized setting(s) and/or the patient, family, or caregiver.

Examples:

- A clinic engages in regular, two-way communication with internal medicine staff managing care in a long-term facility. This includes collaborating on chart notes, phone notes, and order notes.
- A clinic tracks which patients are admitted to local hospitals and actively engages in discharge planning. It schedules follow-up appointments with patients to ensure they receive the care that they need.
- A clinic has regular, direct communication with patients, families, and/or caregivers for patients who are receiving care in SNF. This helps the clinic facilitate care coordination and schedule follow-up care with them.
- Clinic staff coordinate hospital discharge care, follow up with patients, families, and/or caregivers to schedule appointments, deliver medication if needed, and do home visits to check up on patients.
- The behavioral health coordinator has scheduled weekly check ins with the local in-patient behavioral health clinic. They discuss and document admitted patients progress, and any patients ready for discharge. They coordinate follow up appointments with the PCP, and work with the other care coordinators to get transportation services.

Activities that do not meet 5.E.2:

- A clinic only participates in one-way communication with patients (only sends them information).
- A clinic does not demonstrate active involvement with specialized care settings by not regularly following a process to identify and coordinate care for patients in these settings (e.g., it is not actively calling recently hospitalized patients to coordinate follow-up care or is not seeing SNF or long-term care patients on a regular basis).

Specifications for 5.E.3

A clinic is meeting measure 5.E.3 if it is actively involved and coordinates patient care for its patients who are engaged with or receiving services from one or more of the following health-related public benefit systems: the Oregon Department of Human Services, criminal justice system (including juvenile facilities), schools or education systems, and/or public health systems. Coordination must include some form of two-way communication with either the public benefit system(s) and/or the patient, family, or caregiver.

Examples:

- A pediatric clinic works to ensure consistent primary care for its patients in the foster care system by coordinating with their caseworkers or DHS, resource (foster) parents, and/or patients themselves as they experience changes in housing placements. The clinic also works to facilitate the transition out of pediatric care for teens aging out of the foster care system by connecting and/or establishing them with family care practices in their area.
- A clinic identifies which of its child patients with special health needs have IEPs at school and engages in two-way communication with these patients' parents or their school's behavioral health specialists to coordinate their care.
- A clinic provides care coordination services to formerly-incarcerated individuals or those transitioning out of the criminal justice system.[36]

Documentation required at a Verification Site Visit:

Examples of care coordination for these patients. The examples must demonstrate two-way communication with either the public benefit system or the patient, family, or caregiver

Activities that do not meet 5.E.3:

- A clinic refers patients to community-based services as part of its general health-related social needs intervention process (see PCPCH Standard 3.D).
- A clinic with patients in the foster care system does not actively coordinate with these patients, their case workers/DHS, or their guardians regarding their medical care.

[36] See the Center for Care Innovation's Spotlight Article about the Transitions Clinic Program for ideas.

Standard 5.F – End of Life Planning

This is a must-pass standard. Clinics must, at a minimum, meet measure 5.F.0 to qualify for PCPCH recognition.

Measures

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.	**Must Pass**
5.F.1	PCPCH has a process for engaging patients in end-of-life planning conversations and completes advance directives and other forms such as POLST that reflect patients' wishes for end-of-life care.	**5 points**

Intent of Standard 5.F

Arranging for culturally and linguistically appropriate end-of-life and palliative care is an important aspect of care coordination for patients, families, and caregivers. The intent of this standard is to ensure that PCPCHs routinely assess their patients' need and eligibility for hospice or palliative care, when appropriate, and refer patients for these services or coordinate services within the clinic. It is also important that clinics engage their patients, families, and caregivers in end-of-life discussions and ensure that patients' wishes for end-of-life care are documented in advance directive forms available in the patients' medical record or through physician orders recorded in the medical record. The inclusion of advance care planning improves end-of-life care for patients and their caregivers by prioritizing long-term health care decisions and providing clarity about preferences. When there is not a plan in place, patients can receive care that conflicts with their preferences or incur unnecessary medical costs and hospitalizations, often leading to both reduced quality of care and quality of life.

Relevant Definitions

Portable Orders for Life-Sustaining Treatment (POLST): Documentation designed to assure that the medical treatment wishes expressed by the patient are honored by health care professionals as the patient moves from one health care setting to another.

Specifications for 5.F.0

A clinic is meeting measure 5.F.0 if it offers or coordinates hospice and palliative care and counseling services, as clinically indicated. PCPCHs are not required to directly provide hospice or palliative care to meet this measure but must at least have a process in place to refer and coordinate those services when patients and families need them.

Examples:

- A clinic maintains a list of usual referral providers for hospice or palliative care (including admission criteria for these providers) and refers patients when appropriate.
- A clinics' PCP counsels families about hospice or palliative care options in their region.
- A clinic uses hospice or palliative care plans that are developed or approved by its clinicians.

Activities that do not meet 5.F.0

The clinic has a list of hospice or palliative providers/ facilities but cannot provide examples of patient referrals or a policy or protocol for offering these services.

Specifications for 5.F.1

A clinic is meeting measure 5.F.1 if it proactively engages patients, families, and/or caregivers in advanced care planning, including (but not limited to) end-of-life planning discussions, counseling, and completion of POLST and/or advance directives, as appropriate. Forms such as POLST are to be submitted to available registries unless patients opt-out.

Examples:

- A clinic completes end-of-life planning documents with patients such as advanced directives, living wills, or POLST forms that are contained within patient records.
- A clinic develops advanced care plans with its patients and caregiver(s) that detail patients' end of life treatment wishes and consider their primary language and cultural preferences.
- A pediatric practice has a process for engaging in end-of-life planning and counseling for its patients and their families in the rare cases when this is required. This includes counseling or other supportive services for siblings.

Activities that do not meet 5.F.1:

The clinic provides evidence of POLST forms in patient charts, but the forms are not routinely filled out with the help of the providers and the clinic cannot provide any other example of an advance directive nor related counseling to help patients complete the documentation properly.

Additional Resources:

- The Oregon POLST Program (OHSU, also has website and and resources available in Spanish)
- Chinese Community Health Resource Center offers end-of-life resources in Chinese

Standard 6.A – Meeting Language and Health Literacy Needs

This is a must-pass standard. Clinics must, at a minimum, meet measure 6.A.0 to qualify for PCPCH recognition.

Measures

Check all that apply – Select all levels that describe your clinic's activities (max 15 pts):

6.A.0	PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their primary language.	**Must Pass**
6.A.1	PCPCH provides written patient materials in languages other than English.	**5 points** ***Health Equity Measure***
6.A.2	PCPCH assures that patient communications and materials are at an appropriate health literacy level.	**10 points** ***Health Equity Measure***

Intent of Standard 6.A

Ensuring that patients understand their care is a core component of person-and family-centered care. The intent of Standard 6.A is to ensure that PCPCHs communicate with diverse patients, families, and caregivers in their primary language or work with trained health care interpreters. Furthermore, clinics can ensure that patients understand and follow written materials by providing culturally and linguistically appropriate materials in the languages that patients, families, and caregivers can read, at an appropriate health literacy level, and in a way that is accessible by individuals with disabilities.

Definitions

Health literacy: The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

Tele-interpretation: Language interpretation services provided remotely through methods such as telephone interpreting, text telephone (TTY) relay service, or video interpreting.

Specifications for 6.A.0

A clinic is meeting measure 6.A.0 if it offers free-of-charge interpretation services to all patients at the clinic that speak languages other than English. Interpretation services may be provided either on-site through trained health care interpreters or multilingual providers, or remotely via

tele-interpretation.[37] Interpretation services must be available during a patient's entire visit or encounter. Patients may decline the use of interpreters (e.g., if they prefer to have a family member interpret) but should be informed that interpreters are available free of charge and of the advantages to having a trained health care interpreter.

Examples:

- A clinic has a contract with a company that provides real-time telephone or video interpreters to communicate with patients in their language of choice throughout their entire office visit and/or during telephone encounters. The contract states that the company must provide interpreters from OHA's Health Care Interpreter Registry when possible.
- A clinic uses in-person interpreter(s) to communicate with patients in their language of choice throughout their entire office visit and/or during telephone encounters.
- A clinic has bilingual staff to communicate with patients or family members in their language(s) of choice throughout their entire office visit and during telephone encounters. The clinic has a subscription to a tele-interpretation service as a backup for patients that speak a language outside the scope of the bilingual staff.

Activities that do not meet 6.A.0:

- A clinic has multilingual providers available for the most common languages spoken among its patient population (e.g., Spanish), but no plan or process for how to provide interpretation services in the event that a patient speaks a different primary language.
- A clinic routinely relies on the family members of non-English speaking patients to act as interpreters without first offering them free clinic interpretation services.
- A clinic uses google translate.
- Interpreter services, providers, or other employees acting as interpreters are only available at certain times during clinic business hours, but not available at other times and the clinic does not have a strategy to provide alternative options for interpreter services during the times when they are unavailable, or cannot offer proficient interpretation for their patients.

Additional Resources:

- Examples of remote interpreter services include Passport to Languages and LanguageLine Solutions.
- Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (2010) (Joint Commission)
- FAQ for Healthcare Professionals – Information about providing language access services (National Council on Interpreting in Health Care)

[37] Please note that Oregon Administrative Rule requires all clinics to use interpreters from OHA's Health Care Interpreter Registry or to make a "good faith" effort to find an interpreter from this registry. For more information, please contact OHA's Health Care Interpreter Program at HCI.Program@odhsoha.oregon.gov.

Additional Tip

Communicating with patients

To best assess patients' language and communication needs, clinics can document patients' primary language and other communication needs (e.g., sign language, TTY, etc.) and whether interpretation services are needed. This will help identify which patients will benefit from these services and allow you to assess the languages most commonly spoken by your patient population.

Specifications for 6.A.1

A clinic is meeting measure 6.A.1 if it provides vital and routinely used documents (printed and/or electronic) in one or more languages other than English. Clinics must be able to demonstrate that the language(s) selected meet one or more of the following criteria:

- ☐ The most common language(s) other than English spoken by the patient population
- ☐ The most common language(s) other than English spoken within the community that the clinic serves. Clinics can assess the languages spoken in their community using census data, CCO Community Health Assessments (CHAs) or Community Health Improvement Plans (CHIPs), local public health agencies, or other relevant sources.

Examples of vital documents:

- Registration forms
- New patient paperwork
- Consent forms
- Patient education and self-management materials
- POLST forms
- After visit summaries (AVS)
- Screenings for mental health/substance use disorder/developmental conditions
- Grievance policy
- Patient satisfaction surveys
- Clinic signage
- Patient surveys

Documentation required at a Verification Site Visit:

1. Language utilization report of the clinic's population. The clinic must demonstrate with data the predominate languages, in addition to English, that are spoken by their patients, families, and caregivers. If the clinic is instead identifying most common languages spoken in the community, they must provide relevant information or data from census, Community Health Improvement Plan (CHIP), Community Health Assessment (CHA), local public health agency, or other relevant source.
2. Examples of the clinic's vital and routinely used materials available in common primary language(s)

Activities that do not meet 6.A.1:

- A clinic does not translate materials into any language other than English.
- A clinic translates patient materials but does not use language utilization data to understand the languages spoken by its patient population or community.
- A clinic translates materials into Spanish, but cannot provide evidence that Spanish is the most common non-English language spoken by their patient population or community.
- The clinic only has new patient packets available in language(s) other than English, but no other vital documents.

Additional Resources:

Free multilingual health education materials are available from sources such as Medline Plus and EthnoMed.org.

Specifications for 6.A.2

A clinic is meeting 6.A.2 if it has taken steps to assure that commonly used patient materials and/or communication methods are at an appropriate health literacy level for its patient population. Clinics must have engaged in at least one of the following two strategies for ensuring that their patients can understand and act on the information they are given regarding their care:

- ☐ Reviewed and revised written communications/materials to achieve an appropriate reading level or to improve health literacy. This can be performed by trained clinic staff or with the help of external consultants or entities. Written communications might include:
  - Templates
  - Preventive service reminders
  - Test or lab results
  - Websites
  - Forms
  - Handouts
  - Patient education materials and self-management tools
  - Care plans and after-visit summaries (depending on EHR limitations)
  - Other relevant forms of written communication

- ☐ Trained clinic staff that engage in frequent real-time communications (e.g., emails, portal messages, phone conversations, appointments) in health literacy principles or strategies relevant to their patient population. This can be done through direct staff training (e.g., during onboarding, workshops, etc.) or through external resources (conferences, workshops, online modules, consultants, etc.).

Examples:

- A clinic reviews its patient education materials, after-visit summaries, and preventive service reminders to ensure that these are at an appropriate health literacy level. It translates these materials into a more appropriate reading level, adjusts the font and layout for patients with a range of visual needs, reduces the use of confusing medical terminology, adds (or links to) useful illustrations and guides/definitions, and offers alternative formats/options for patients with visual disabilities.

- A clinic trains its providers and MAs on health literacy principles such as reducing jargon, checking for comprehension, and explaining things in ways that consider their patients' health literacy needs. Staff are trained in health literacy assessment strategies, offering patients opportunities to get clarification, leveraging the help of peers, and/or making patients aware of who they can contact if they have additional questions or need materials in another format.
- A clinic partners with a health literacy consultant to review and update its website and certain patient communication workflows/technologies for health literacy. The clinic also considers health literacy when leveraging or comparing external sources of written templates and communication tools.

Documentation required at a Verification Site Visit:

1. List of written communications revised for health literacy, or list of staff roles that received training in health literacy
2. Examples of written communications that have been revised, or evidence/source of health literacy training(s)

Activities that do not meet 6.A.2:

- A clinic chooses to meet this measure using written communications but has only reviewed one type of document for health literacy and has not considered any other written communications that patients may have trouble understanding.
- A clinic chooses to meet this measure using trainings but cannot describe the health literacy principles or specific health literacy training sources that were used to train its staff.

Additional Resources:

- Health Literacy Solutions Center (Institute for Healthcare Advancement)
- Strategies to Improve Organizational Health Literacy, Health Literacy Improvement Tools, and Personal Health Literacy Measurement Tools (Agency for Healthcare Research and Quality)
- The Guide to Providing Effective Communication and Language Assistance Services (Think Cultural Health)
- Common and confusing terms used in the doctor's office (2023) (Antidote.me, McDowell)
- Health Literacy, Primary Care Health Care Providers, and Communication (2021) Health Literacy Research and Practice, Mor-Anavy et al.)
- Health literacy in primary care practice (2015) (American Family Physician, Hersh, Salzman & Snyderman)
- Health Literacy Practices in Primary Care Settings: Examples From the Field (2008) (The Commonwealth Fund, Barrett, Westpheling & Puryear)

Standard 6.B – Education and Self-Management Support

This is not a must-pass standard. Clinics can qualify for recognition as a PCPCH by meeting the point total that determines their overall Tier level of recognition without meeting this standard.

Measures

Progressive – Select the level that best describes your practice (max 10 pts):

6.B.1	PCPCH provides culturally or linguistically appropriate patient-specific education resources to its patient population.	**5 points**
6.B.2	PCPCH provides culturally or linguistically appropriate patient-specific education resources and offers or connects patients, families, and caregivers with self-management support resources.	**10 points** ***Health Equity Measure***

Intent of Standard 6.B

A critical component of patient and family-centered care is empowering patients to manage their own health and wellness with support from their families and caregivers through patient engagement and self-management support. The intent of this standard is to ensure that PCPCHs give their patients, families, and caregivers the tools they need to engage in self-management behaviors in a way that is culturally and linguistically appropriate for their patient population.

Relevant Definitions

Culturally or linguistically appropriate care: A manner of delivering health care services that is respectful of and responsive to the cultural or linguistic needs of all individuals by considering characteristics such as race, ethnicity, language, disability status, sex, gender identity, sexual orientation, age, social class, geographic region, life circumstances, religious or spiritual identity, values, or other sociological characteristics. For the purposes of PCPCH Standard 6.B this may also include efforts to address patient health literacy barriers.

Patient-specific education: A clinic engages in patient-specific education if it imparts information to its patients and/or caregivers that is intended to improve their individual health status and is based on their specific health conditions and needs (as opposed to general "patient education" which targets an entire patient population).

Self-management support: A clinic engages in self-management support if it provides or coordinates training for its patients on how to effectively manage their own health. This support can come in various forms such as templates, action plans, home monitoring flowsheets, care plans, behavior change readiness or self-management readiness assessment tools, and other chronic pain or stress management strategies. It can also come in the form of group activities intended to train or engage patients in self-management strategies such as support groups,

peer-learning, or workshops/classes (e.g., diabetes walking groups or Living Well with Chronic Conditions classes). These groups can be facilitated by the clinic itself or external organizations and service providers.

Specifications for 6.B.1

A clinic is meeting measure 6.B.1 if it ensures that up-to-date, culturally or linguistically appropriate patient-specific education resources are routinely provided to patients, families, and/or caregivers on a variety of topics that are relevant to the clinic's diverse patient population. Clinics should leverage information about their unique patient population (such as most common languages, health literacy level, cultural background, disabilities, or other relevant life circumstances) to identify and/or draft patient education materials and/or provide multiple options.

Examples:

- A clinic provides patients reading information following a diabetes diagnosis. The materials used have pictures, diagrams, and non-medical or common terms to help patients understand the causes, progression, lifestyle changes, and treatment options for this condition. The clinic makes these materials available in both English and Spanish to accommodate the most common primary languages spoken among their patient population.
- A clinic provides caregivers with online resources about normal childhood development during well child check appointments. The online resources are gender-affirming and include educational videos that may be helpful for patients with low health literacy.
- A clinic takes steps to ensure that its patient-specific educational materials are accessible to patients with visual or hearing disabilities.

Documentation required at a Verification Site Visit:

Examples of culturally or linguistically appropriate patient-specific educational resources that are routinely provided to patients, families, and caregivers (e.g., pamphlets, brochures, printed handouts, online links)

Activities that do not meet 6.B.1:

- A clinic offers general patient educational resources to its entire patient population (such as a poster in the lobby) that are not specific to the individual conditions or health needs of a patient.
- A clinic offers patient-specific educational resources but has not taken steps to make them culturally or linguistically appropriate (see definition above).

Additional Resources:

Developing culturally CAPABLE materials (Think Cultural Health)

Specifications for 6.B.2

A clinic is meeting measure 6.B.2 if it is doing both of the following:

- ☑ It ensures that up-to-date culturally or linguistically appropriate patient-specific education resources are routinely provided to patients, families, and/or caregivers on a variety of topics that are relevant to the clinic's diverse patient population (see specifications for 6.B.1).
- ☑ It offers or coordinates culturally or linguistically appropriate self-management support resources for patients which further their ability to effectively manage their health (e.g., self-management support tools, workshops, referrals to or partnerships with community-based organizations, etc.

Clinics should leverage information about their unique patient population (such as most common languages, health literacy level, cultural background, disabilities, or other relevant life circumstances) when they are identifying, developing, or updating patient-specific education materials and self-management support resources and referrals.

Examples:

- In order to promote healthy behaviors, a clinic provides culturally and linguistically appropriate patient-specific education to its patients regarding their specific condition, impactful behaviors, and age-appropriate anticipatory guidance. The clinic also provides patients who have specific chronic conditions with home monitoring worksheets that have been designed to accommodate patients with a variety of reading levels and vision needs (e.g., colors, font sizes, jargon use, etc.).
- A clinic with a significant proportion of patients whose primary language is Russian ensures that its patient education materials and self-management resources are specific. For example, the clinic connects relevant patients with diabetes to either a local English-speaking walking group or a Russian-speaking walking group to ensure that its patients are able to experience the quality of self-management support regardless of language.

Additional Tips

Collaborating with local community organizations

To best engage patients in self-management opportunities, PCPCHs can assess their patient population's needs in this arena, identify local community organizations that have relevant resources and training, and provide those services collaboratively. Traditional Health Workers can be a useful resource to patients as they navigate what self-management resources work best for their individual lifestyle and needs (e.g., nutrition, cooking, or meditation classes). Many regions across Oregon have local community or governmental organizations that are willing to collaborate with clinics in supporting their patients.

Documentation required at a Verification Site Visit:

1. Examples of culturally or linguistically appropriate patient-specific educational resources that are routinely provided to patients, families, and caregivers (e.g., pamphlets, brochures, printed handouts, online links)
2. Examples of culturally or linguistically appropriate self-management support resources (e.g., self-management support tools, workshops, community-based organizations, etc.)

Activities that do not meet 6.B.2:

- A clinic provides standard patient-specific education resources and self-management support resources but has not taken steps to tailor those resources to their unique patient population or consider which resources are most culturally or linguistically appropriate.
- The clinic offers culturally and linguistically appropriate patient-specific educational resources but does not offer any self-management support resources.

Additional Resources:

- Health Education Classes and Self-Management Programs (Oregon Health Authority)
- Partnering in Self-Management Support – Toolkit for Clinicians (Institute for Healthcare Improvement)
- Self-Management Support (Agency for Health Research and Quality)

Transformation in Practice

Meeting the intent of all measures in 6.B

A primary care clinic that serves a culturally and linguistically diverse patient population has struggled to help their newly diagnosed diabetic patients understand how to manage their condition. In response, the clinic seeks out robust educational materials for patients on the causes, progression, lifestyle changes, and treatment options for diabetes in English, Spanish, and Arabic – the top three languages spoken among patients in the clinic.

In addition to offering patient-specific educational materials about diabetes to their patients, the clinic offers self-management support by training its patients on how to effectively manage diabetes through home monitoring flowsheets and SMARTIE goals.

Finally, the clinic facilitates ongoing *Living Well with Chronic Disease* classes that help patients learn how to implement and practice lifestyle changes like nutrition and exercise to help bring their diabetes under control—with each class attended by relevant interpreters. It also connects patients to local wellness opportunities, such as yoga classes, at a nearby community center.

Standard 6.C – Experience of Care

This is a must-pass standard. Clinics must, at a minimum, meet measure 6.C.0 to qualify for PCPCH recognition.

Measures

Progressive – Select the level that best describes your practice (max 10 pts):

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.	**Must Pass**
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.	**5 points**
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.	**10 points** ***Health Equity Measure***

Intent of Standard 6.C

To be truly person- and family-centered, a primary care home should understand the care experiences of its diverse patients, families, and caregivers and seek to improve them, as well as reduce disparities in experience where appropriate. Strategic survey planning and survey data utilization makes this process meaningful and can have a significant impact on improving patient experience of care.

Relevant Definitions

Culturally and linguistically appropriate: A manner that is respectful of and responsive to the cultural and linguistic needs of all individuals by considering characteristics such as race, ethnicity, language, disability status, sex, gender identity, sexual orientation, age, social class, geographic region, life circumstances, religious or spiritual identity, values, or other sociological characteristics. For the purposes of Standard 6.C, a clinic might consider these characteristics when designing or selecting their survey tools and overall survey strategy.

Health equity: For the purposes of Standard 6.C, this refers to efforts to deliver primary care services that allow all patients to reach their full health potential and well-being without being disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, geographic location, intersections among these communities or identities, or other socially determined circumstances.

***Patient panel*:** The group of patients that are assigned to an individual provider in the clinic's EHR system. This number can vary from provider to provider. There is no required minimum or maximum number of patients that a provider must have on their panel. Each provider's patient panel should be updated and maintained. Inactive or deceased patients should be removed from the patient panel for the purposes of this standard (see Standard 4.A.0 for definition of "active patient."

Specifications for 6.C.0

A clinic is meeting measure 6.C.0 if it surveys its patients, families, and/or caregivers on their experience of care at least once every two years in a way that meets the following criteria:

- ☑ Clinic surveys patients directly or through a third-party vendor. Surveys are collected on paper, via telephone, or electronically.
- ☑ Clinic surveys patients in a way that is both random and anonymous. Examples of appropriate survey methodologies include distributing a patient survey to every fifth patient or surveying all patients with appointments during a specific time period.
- ☑ The patient experience survey includes questions that assess access to care, provider or health team communication, coordination of care, and staff helpfulness. The CAHPS survey is recommended, but not required, and can be used as a resource when brainstorming survey questions around these subjects. CAHPS Survey tools are available at no cost from the Agency for HealthCare Research and Quality (AHRQ). The CAHPS Clinician and Group Survey with Patient-Centered Medical Home items is recommended.
- ☑ Clinic obtains survey results from at least 3% of each primary care provider's assigned patient panel or has a defined strategy to improve survey response rates that includes how and when the practice will meet the 3% per-provider threshold. All primary care providers with a patient panel at the clinic must be included in the survey process, regardless of how many hours the provider offers care during the week. Primary care providers who have been with the clinic for less than 6 months from the time the survey was administered are exempt from survey data analysis. Table 6.C below shows examples of the number of surveys that would need to be returned per provider based on differently-sized patient panels.

Table 6.C – Examples of 3% survey return rate per provider

Provider's assigned patient panel	Minimum surveys required (3%)
2,250 patients	68 surveys
1,500 patients	45 surveys
1,050 patients	32 surveys

- ☑ Clinic includes all completed survey results in reported data. Fifty percent or more of the survey questions must be answered for the survey to be considered complete and count towards the minimum requirement of 3 percent of surveys per provider.
- ☑ Clinic routinely shares survey results with staff.

Example:

A clinic is having difficulty applying patient feedback it receives from survey data to its daily operations and has challenges with patients completing surveys. Staff decide to create an action plan to increase the number of surveys returned per provider. The plan includes a a workflow to engage staff in distributing paper surveys to patients at every upcoming appointment for a specific provider, rotating providers each month. They allow time for monthly data entry and tracking. Every 6 months, the survey data is presented to the clinic staff in a meeting and posted on the quality board in the break room. This helps staff feel engaged in the process, identify areas for improvement, and see their progress.

Additional Tips

Conducting patient experience of care surveys

Below are some additional tips on how to make the most out of your surveys:

- For feedback that is truly representative of your entire patient population, make sure to survey each of your diverse patient groups (e.g., administer both adult and child-specific questionnaires, make the questionnaire available in different languages, etc.)
- Include patients who have had at least one visit in the target time frame (e.g., if using CAHPS, this would be the previous 6 or 12 months, depending on the survey version used).
- Include all patients who meet the sampling criteria even if they are no longer receiving care from the clinic, site/clinic or provider.
- Work to ensure that the sample selected for data collection is de-duplicated so that each patient is only represented once.
- Ensure that survey tools are available in multiple languages, alternative formats (e.g., consider disabilities), and take health literacy into account.
- Ensure that survey tools/questions are gender-affirming and culturally and linguistically appropriate for your unique patient population.

Documentation required at a Verification Site Visit:

1. Copy of the paper survey, electronic survey, or phone script used to collect patient feedback
2. Provider-level survey data for each area of patient experience (access to care, provider or health team communication, coordination of care, and staff helpfulness). This must include survey dates, panel size and the response rate for each provider.
    - *If a clinic is not meeting the 3%-per-provider threshold*, they must also provide a description of their strategy/action plan for meeting it
3. Evidence of the survey results being routinely shared with staff (e.g., PowerPoint presentations, meeting minutes, etc.)

Activities that do not meet 6.C.0:

- A clinic has not collected the minimum survey requirement of 3% of each primary care provider's patient panel within the last two years and does not have a defined a strategy to improve patient response rates.
- A clinic can present clinic-level data but is unable to review data on an individual-provider level.
- A clinic's survey questions do not cover all four areas of patient experience: access to care, provider or health team communication, coordination of care, and staff helpfulness.
- A clinic collects survey data but does not share the survey results with its staff.

Specifications for 6.C.1

A clinic is meeting measure 6.C.1 if it meets all the specifications for 6.C.0 and uses its survey data for quality improvement activities.

Example:

A clinic has two providers, each with a small patient panel, and has developed its own survey using inspiration from the CAHPS survey domains. When its quality team meets to discuss survey results, they find that "Staff Helpfulness" is their lowest scoring domain. Through Plan, Do, Study, Act (PDSA) cycles, they develop training for staff to address the issues and continue to monitor staff helpfulness and share results at their all-staff meetings.

Documentation required at a Verification Site Visit:

1. Copy of the paper survey, electronic survey, or phone script used to collect patient feedback
2. Provider-level survey data for each area of patient experience (access to care, provider or health team communication, coordination of care, and staff helpfulness). This must include survey dates, panel size and the response rate for each provider.
    - *If a clinic is not meeting the 3%-per-provider threshold*, they must also provide a description of their strategy/action plan for meeting it
3. Evidence of the survey results being routinely shared with staff (e.g., PowerPoint presentations, meeting minutes, etc.)
4. Demonstration of how clinic utilized survey results in a quality improvement activities

Activities that do not meet 6.C.1:

A clinic is unable to demonstrate how survey results are utilized in quality improvement activities.

Specifications for 6.C.2

A clinic is meeting measure 6.C.2 if it is meeting the specifications for 6.C.0 and 6.C.1, and includes questions or domains intended to consider or improve health equity in its survey(s). Clinics can include these questions in their standard survey or administer them as a supplemental survey. Ideally, clinics would also consider how to administer their survey(s) or collect data in a way that is culturally and linguistically responsive and responds to common needs among their unique patient population, as well as consider the various barriers to participation experienced by patient groups that are typically under-represented in their surveys.[38]

Examples of Health Equity-Related Questions

CAHPS offers supplemental questions that can be added to surveys such as survey questions pertaining to health literacy, questions related to interpreter services, questions related to perceived bias, questions pertaining to people with mobility impairments, and other topics relevant to health equity. Clinics can use these questions or identify other equity-related questions or survey tools. Clinics developing their own questions are encouraged to collaborate with internal consultants (e.g., their DEI team or other relevant staff) or external consultants (e.g., survey vendors, equity education organizations, community-based organizations) to best capture relevant experiences among their unique patient population.

Documentation required at a Verification Site Visit:

1. Copy of the paper, electronic, or phone survey(s) used to collect patient feedback that includes questions related to health equity
2. Provider-level survey data for each area of patient experience (access to care, provider or health team communication, coordination of care, and staff helpfulness). This must include survey dates, panel size and the response rate for each provider.
    - *If a clinic is not meeting the 3%-per-provider threshold*, they must also provide a description of their strategy/action plan for meeting it
3. Evidence of the survey results being routinely shared with staff (e.g., PowerPoint presentations, meeting minutes, etc.)
4. Demonstration of how clinic utilized survey results in a quality improvement activities

Activities that do not meet 6.C.2:

A clinic has a robust survey process that address multiple areas of care but cannot identify specific questions or domains intended to consider or improve health equity.

Additional Resources:

- Brooklyn Health Equity Index Webinar (NY Health Foundation, 2023)

[38] Karin, J. (2022) Equity and Accessibility Issues with Patient Experience Questionnaires. *Massachusetts Health data Consortium*.

Additional Tip

Leveraging survey results to improve health equity

PCPCHs are encouraged to consider leveraging their survey results to improve health equity. This can be done by either analyzing the feedback on survey questions designed specifically to assess health equity (see PCPCH Measure 6.C.2) or by segmenting standard survey questions by patient characteristics such as race, ethnicity, language, disability status, gender, gender identity, sexual orientation, age, special or complex health needs, social class, geographic region, life circumstances, health-related social needs, or other characteristics relevant to the clinic's patient population to identify groups that are experiencing disparities in a particular area of care. Clinics can then incorporate these insights into their improvement efforts.

Standard 6.D – Communication of Rights, Roles and Responsibilities

This is a must-pass standard. Clinics must meet 6.D.0 to qualify for PCPCH recognition.

Measure

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.	**Must pass**

Intent of Standard 6.D

Information exchange and communication are essential components of patient and family-centered care. Available evidence shows a strong association between information sharing and patient empowerment, self-management through better adherence to medications, improved chronic disease control, and reduced costs of care. The intent of this standard is to facilitate this exchange between patients, caregivers, families, and providers. Clarifying patient, family, and caregiver roles and responsibilities as part of a care team before or at the time of their first visit can be an effective start to building long-lasting and trusting relationships. Patients, families, and caregivers should understand their role as the most important member of their health care team and should be encouraged to partner with their health care team so that they receive the best possible care.

Specifications for 6.D.0

A clinic is meeting measure 6.D.0 if it provides every patient with an informational brochure or document upon checking in for their first visit or by mail before their first visit. The brochure or document should include:

- ☑ Hours of operations and after-hours contact information
- ☑ Expectations of patients, families, or caregivers to prepare for their visits
- ☑ Rules, policies, or procedures that every patient, family, or caregiver should be aware of
- ☑ Expected maximum response times for patient, family, and caregiver requests
- ☑ Explanation of health care team roles and responsibilities
- ☑ Description of patients' rights and clinic-specific grievance policy[39]

[39] Beyond the HIPAA grievance policy that is required by law, a clinic-specific grievance policy should encompass all aspects of patient care so that patients are empowered to report on a variety of issues in addition to privacy violations (e.g. staff communication).

Clinics are encouraged to consider the health literacy level of the brochure or document as well as its accessibility to patients with disabilities or primary languages other than English.

Documentation required at a Verification Site Visit:

Copy of the brochure or document provided to patients

Activities that do not meet 6.D.0

The clinic only provides the HIPAA grievance policy within its materials rather than a complete clinic-specific grievance policy and description of patients' rights.

Additional Resources:

See Standard 6.A.2 for resources and guidance around improving the health literacy level of patient materials.

Standard 6.E – Cultural Responsiveness of Workforce

This is a must-pass standard. Clinics must, at a minimum, meet measure 6.E.0 to qualify for PCPCH recognition.

Measures

6.E.0	PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.	**Must pass**
6.E.3	PCPCH partners with one or more traditional health workers or traditional health worker services.	**15 points** ***Health Equity Measure***

Intent of Standard 6.E

A patient's background, culture, identity, and social circumstances can significantly impact their health-related priorities, trust for their medical home, and overall experiences with primary care. The intent of this standard is for PCPCHs to take steps to understand their patient population and deliver care in a way that is culturally responsive, trauma-informed, and improves overall trust.

Relevant definitions

Culturally and linguistically appropriate care: A manner of delivering health care services that is respectful of and responsive to the cultural and linguistic needs of all individuals by considering characteristics such as race, ethnicity, language, disability status, sex, gender identity, sexual orientation, age, social class, geographic region, life circumstances, religious or spiritual identity, values, or other sociological characteristics. A clinic might consider these characteristics during patient empanelment, preventive outreach, referrals, communications, staff training, quality improvement, patient education, development of self-management resources, and more.

Traditional health worker (THW): A health care worker that specializes in understanding a particular community or patient population and delivering care in a way that respects their background, values, needs, experiences, and/or priorities. Examples of THWs include Community Health Workers, Personal Health Navigators, Birth Doulas, Peer Support Specialists

(including Family Support Specialists, Youth Support Specialists, Recovery Peers, and Mental Health Peers), Peer Wellness Specialists, End-of-Life Doulas,[40] and other similar roles.[41]

Trauma-informed care: A manner of delivering health care services that integrates knowledge about trauma including its impact on patients and staff, its signs and symptoms, paths for recovery, and how to actively avoid re-traumatization.

Trust-building care: A manner of delivering health care services that works to build trust between staff and patient populations that are concerned about privacy, informed consent, hidden motives, malintent, or mistreatment by the overall healthcare system as a result of unfamiliarity, prior negative experiences, or historical injustices.

Specifications for Measure 6.E.0

A clinic is meeting measure 6.E.0 if it assures that each of its primary care providers have received training in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care within the last two years. The type of training should be relevant to the clinic's unique patient population and focus on how its patients' background, culture, identity or social circumstances impact their experiences and priorities with regards to health care. Clinics can either offer this training directly or partner with external entities.

Examples:

- A clinic requires that all its primary care providers take a virtual training on how to deliver trauma-informed care at least once every two years.
- As part of its onboarding process, a rural clinic has developed its own training for its primary care providers on the barriers and priorities that local patients face around transportation and food insecurity and how to engage patients in discussions about self-management in a way that acknowledges their more immediate priorities. The clinic offers a "refresher training" every two years for its primary care providers that already received the initial onboarding training.
- A general family medicine clinic requires that each of its primary care providers attend a workshop hosted by a local community-based organization on LGBTQIA2S+ concerns and barriers within the health care system and how to deliver high-quality and identity-affirming care to members of this community. The following year, the clinic has its PCPs take a virtual training on trauma-informed care.
- A clinic decides to offer different (or modified) trainings to its primary care providers based on their role or assigned patient population. For example, two of its providers are bilingual and are typically empaneled with patients who are Latino/a. These two providers receive training every two years on this community's cultural and language norms around

[40] More information about End-of-Life Doulas can be found at the National End-of-Life Doula Alliance website.

[41] See OHA's Equity and Inclusion Division's webpage About Traditional Health Workers for more information.

mental health, chronic health, and end-of-life care to make sure that conversations and referrals take these into account.

- A youth-oriented clinic partners with a local youth counselor association to train its providers every two years on the evolving concerns that young people face in disclosing sexual health and drug use (e.g., fear of parental retribution) and how to approach conversations about these topics in a way that assures privacy and builds trust.

Documentation required at a Verification Site Visit:

Policy, procedure, or workflow demonstrating the type of training(s) that primary care providers receive including the topic(s), source(s) and when this training is administered

Activities that do not meet 6.E.0:

- A clinic does offer or facilitate training, but not all primary care providers at the clinic receive this training.
- Primary care providers have received training, but it was more than two years ago, and they have not received a refresher or training in any other topic since.

Additional Tips

Ensuring meaningful training

PCPCHs can explore the strategies below to ensure that their staff and patients are receiving the full benefits of these trainings:

- Facilitate trainings for all types of providers and staff at the clinic, adjusting content as needed for various roles.
- Integrate trainings into the clinic's culture and operations (make them part of the onboarding process, communication trainings, continuing education, professional development, etc.).
- Ensure that the trainings themselves are trauma-informed for those receiving them (i.e., consider staff needs and experiences).
- Partner with local CBOs or other relevant organizations for guidance, specific trainings, or suggestions on how to best serve a particular population.

Additional Training Resources (including free or low-cost):

- Trauma Informed Oregon - Training Modules
- HHS – Culturally and Linguistically Appropriate Trainings
- The National LGBTQIA+ Health Education Center
- Coordinated Care Organizations
- Regional Health Equity Coalitions (RHECs)
- Local Public Health Departments

- Equity & Inclusion Division – Training Opportunities *(see continuing education resources)*
- Trauma-Informed Care Implementation Resource Center
- Community-Based Organizations that serve specific populations

Specifications for Measure 6.E.3

A clinic is meeting measure 6.E.3 if it partners with one or more Traditional Health Workers (THWs) or THW services in delivering care to patients. THWs include Community Health Workers, Personal Health Navigators, Birth Doulas, Peer Support Specialists (including Family Support Specialists, Youth Support Specialists, Recovery Peers, and Mental Health Peers), Peer Wellness Specialists, End-of-Life Doulas, or other similar roles. The type of THW selected must be relevant to the clinic's unique patient population and be available on an ongoing basis. Clinics can choose to either partner with an external THW or integrate them into the clinic, but must be able to demonstrate that the THW has been trained or credentialed accordingly for their role. Clinics may, for example, require that their THWs have received THW certification under the Oregon Health Authority or a similar program, or may have their own unique training requirements for THWs. Staff serving as THWs may have other roles at the clinic as well as long as they have been trained or certified as a THW and are delivering THW services to their patients on an ongoing basis.

Examples:

- A Women's Health Center hires three part-time birth doulas, offering to pay the credentialing fees for those who are not yet certified with the OHA to ensure that all doulas are properly credentialed within two years.
- A rural clinic takes steps to identify what types of THW services are available in their area and determines that partnering with a local peer support specialist agency would be especially beneficial to their patient population. They develop a workflow for offering peer support specialists to patients struggling with substance use, and all are trained and credentialed through their agency to facilitate care for this subgroup.
- A clinic determines that its low-income patients are having difficulty navigating their services and that a community health worker could improve quality of care, use of preventive services, and adherence to treatment. The clinic partners with their local coordinated care organization to provide CHW services to their OHP patients on a weekly basis.
- A clinic determines that its Latino/a/x patients would benefit from personal health navigators. The clinic develops its own credentialing process for their personal health navigators that includes training around how to best support this subgroup of patients.

Documentation required at a Verification Site Visit:

1. Either a THW job description or evidence of a workflow involving THW services
2. Evidence of THW credentials or a training plan

Activities that do not meet 6.E.3:

- A clinic has utilized the services of a THW in the past, but a THW is not involved in facilitating patient care at the clinic on an ongoing basis.
- A clinic refers patients to an external agency with THWs but does not communicate or collaborate with the THW(s) to facilitate patient care.

Additional THW-related Resources:

- THW Trainings (OHA)
- Information for Health Systems, Providers, and THWs (OHA)
- Traditional Health Worker Billing and Payment (OHA)
- THW Toolkit (OHA)
- Resources for Various THW Types (OHA)

Patient-Centered Primary Care Home Glossary

Below are the PCPCH Program's definitions for terms that are used throughout the model to define the criteria for various standards.

Active patients: Patients who have had at least one office visit with any primary care clinician or team member at the clinic during a set time period prior to PCPCH application submission. This time period can vary by clinic but is typically between 12 months and 36 months.

Care coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care, in order to facilitate the appropriate delivery of health care services. Organizing care involves investment in personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

> **Coordination of services:** A clinic is considered to be coordinating a service if it has a policy, process, and/or workflow to ensure that patients can access the service in a safe and timely way. Different standards have different expectations around what coordination activities occur within the clinic. Examples include, but are not limited to:
>
> - Care coordination functions listed in the "Additional Tips" box in 5.C (page 127)
> - Initiating and/or tracking referrals to specialty providers or community organizations
> - Collaborating with external providers or organizations on services
> - Designating care coordinators within the clinic
>
> **Care coordinators:** One or more staff members who are responsible for the provision and coordination of services for the clinic's population. Care coordination functions may be delegated to multiple staff (either clinical or non-clinical) as long as coordination roles are clearly defined. Different standards have different expectations for care coordinators.

Chart audit / Chart review: An internal records audit that clinics can conduct to assess their own activities and performance. Clinics may use chart audits for practice improvement, self-assessment, or (in select standards) to submit data to the PCPCH program that cannot be pulled as a report from their EHR, in which case a sample size of at least 30 active patient records is required. The measurement period from which this sample must be drawn varies by standard, but typically spans the last 6 or 12 months.

Clinician: A healthcare professional qualified in the clinical practice of medicine that provides principal care for a patient where there is no planned endpoint of the relationship, expertise needed for the ongoing management of a chronic disease or condition, care during a defined period and circumstance (such as hospitalization), or care as ordered by another clinician. Clinicians may be physicians, nurses, pharmacists, or other allied health professionals (CMS). Some PCPCH standards (e.g. 4.A) use "clinician" to refer to a smaller subset of health

professionals: a licensed physician, resident physician, physician assistant (PA) or nurse practitioner (NP).

Co-location of services: Services are co-located when they share the same physical location and involve access to the medical record. Services are not co-located if a patient needs to travel to separate locations to access them.

Collaborating on care: A clinic is considered as collaborating with a specialty provider or partnering organization on care if it engages in meaningful communication or joint coordination of a service. Different standards have different expectations around what collaborative activities occur between the clinic and external parties. Examples include, but are not limited to:

- Regular communication or meeting times
- Shared protocols for care/medication management
- Collaborative Care Compacts
- Shared medical records or access to chart notes
- Cooperative/collaborative referrals
- Co-management of care

> **Co-management of care:** This occurs when a patient's provider or care team collaborates with a specialty provider or partnering organization on their care in a way that involves either a systemic, 2-way communication method OR shared medical record. Shared medical records do not necessarily require the use of the same electronic health record, but chart notes should be available to all treating providers at the time of each visit. Different standards have different expectations for co-management of care which are included in the technical specifications.

Community-based organization/resource/agency: A public or private organization that is representative of a community or a significant segment of a community and works to meet community needs.

Culturally and linguistically appropriate care: A manner of delivering health care services that is respectful of and responsive to the cultural and linguistic needs of all individuals by considering characteristics such as race, ethnicity, language, disability status, sex, gender identity, sexual orientation, age, social class, geographic region, life circumstances, religious or spiritual identity, values, or other sociological characteristics. A clinic might consider these characteristics during patient empanelment, preventive outreach, referrals, communications, staff training, quality improvement, patient education, development of self-management resources, and more.

Diverse patients: Patients that vary by age, sex, race, ethnicity, primary language, disability, sexual orientation, gender identity, health condition, and length of time as a patient at the clinic, among other characteristics.

Electronic Health Record (EHR): A digital version of a patient's paper chart that is real-time and makes information available instantly and securely to authorized users. Visit HealthIT.gov for further information about EHRs.

> A **Certified Electronic Health Record** is an EHR that is certified through the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. The Certified Health IT Product List contains an updated list of all EHRs that are certified by CMS. All PCPCHs are required to use a certified EHR. See Standard 4.C.0 for more information about this requirement.

Health disparities: Differences in the presence of disease, health outcomes, or access to health care services between various populations that are not due to differences in health care needs or patient preferences.

Health equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including Tribal Nations, to address the equitable distribution or redistributing of resources and power, and recognizing, reconciling and rectifying historical and contemporary injustices. Clinics can take steps to advance health equity through efforts like:

- Increasing clinic staffs' understanding the diversity of their patient population
- Engaging patients, their families, and caregivers in their own health care
- Engaging diverse patients, their families, and caregivers in clinic-level quality improvement efforts
- Assessing disparities in access to services, care received, or health outcomes
- Integrating the reduction of disparities into quality improvement and practice transformation
- Meeting the communication needs of diverse patients
- Providing team-based care to diverse patients
- Addressing the social determinants of health or health-related social needs

Health-Related Social Needs (HRSN): Social barriers which affect people's ability to maintain their health and well-being. Examples include housing instability, lack of housing quality, food insecurity, interpersonal violence, lack of transportation, utility needs, insufficient education or training, insufficient employment or income, etc.

Integration of services: A service has been integrated into a clinic if the clinic routinely assesses their patients for related conditions and provides appropriate treatment and care coordination for these conditions. A non-primary care specialist has been integrated into a clinic if they meet **all** of the following criteria:

- ☑ Are co-located with the clinic or patients can access their full range of services without needing to travel to a separate location from the clinic

- ☑ Review shared medical records and assesses patients' status
- ☑ Meet with clinic patients and caregivers to obtain and document patient history
- ☑ Engage in the primary care workplace structure and teams (ex: meeting with PCPs to discuss complex patient management or designing and implementing shared care plans together with patients)
- ☑ Are available to consult or accept warm handoffs during primary care appointments
- ☑ Engage in additional activities as specified by various standards

LGBTQIA2S+: People who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual, two-spirit, or pansexual.

Patient education (health education): A clinic engages in patient education if it imparts information to its patient population with the intent of providing context or altering health and safety behaviors of the patient population as a whole. Examples include forms, posters, flyers, letters, or other communications providing information about conditions, behaviors, further education and peer learning, or age-appropriate anticipatory guidance. (E.g., clinic has poster in lobby with information about achieving adequate nutrition).

> Some Standards require **patient-specific education** which is based on the health conditions and needs of a specific patient and/or caregiver and intended to improve their individual health status. (E.g., a patient is provided information following a diabetes diagnosis about the causes, progression, and treatment options for this condition).

Referrals: A clinic engages in referrals when it directs a patient to a specialist, service, or organization external to the clinic. Different PCPCH standards have different expectations around referrals.

> **Cooperative/collaborative referrals:** Clinic has a partnership or cooperative agreement with a specialist or organization which involves either a shared medical record or two-way communication regarding patients' referral status (ex: organization sends monthly list to clinic with patients that received referred services).
>
> **Referral follow-up:** A clinic engages in referral follow-up if it systematically contacts patients and/or the external organizations/specialists to determine whether the patient followed through with a referral or what barriers prevent them from doing so.
>
> **Referral tracking**: A clinic engages in referral tracking (sometimes referred to as "***closed-loop referrals***") if it keeps a record of referrals, referral follow-up, and referral statuses. Referral tracking typically includes the referral information (i.e., service, specialist, organization), the results of referral follow-up activities (i.e., whether contact was achieved, barriers that prevented patients from completing a referral, and any attempts to address those barriers), and the final outcome of the referral (i.e., whether patients received the appointment/ service).

Screening: The presumptive identification of unrecognized disease in an apparently healthy, asymptomatic population by means of tests, examinations or other procedures that can be applied rapidly and easily to the target population. Screenings are generally expected to be evidence-based and age- and gender-appropriate. Examples of screening tactics include paper surveys, verbal questioning, or physical examination. Verbal questioning cannot be reactive to a patient's symptoms during an appointment to be considered screening; screening must be routine and systematically administered to all patients meeting a defined criterion.

> Most PCPCH standards that reference screening require **universal screening**, meaning that all patients are screened for a condition or group of conditions in a method that is evidence-based and appropriate/relevant to their age and gender. Different screening tools or protocols may be used for different populations (such as adults and children), but all relevant patients must be included.

Self-management support: A clinic engages in self-management support if it provides or coordinates training for its patients on how to effectively manage their own health. This support can come in various forms such as templates, action plans, home monitoring flowsheets, care plans, behavior change readiness or self-management readiness assessment tools, and other chronic pain or stress management strategies. It can also come in the form of group activities intended to train or engage patients in self-management strategies such as support groups, peer-learning, or workshops/classes (e.g., diabetes walking groups or Living Well with Chronic Conditions classes). These groups can be facilitated by the clinic itself or external organizations and service providers. Different standards have different expectations around self-management support services.

Substance use disorders: These occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Telehealth/telemedicine: The mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care. Telemedicine/telehealth includes:

- Health services transmitted via landlines, wireless communications, Internet and telephone networks;
- Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices; and
- Communications between providers or between one or more providers and one or more patients, family members, caregivers or guardians.

Traditional Health Worker (THW): A health care worker that specializes in understanding a particular community or patient population and delivering care in a way that respects their background, values, needs, experiences, and/or priorities. Examples of THWs include:

- Community Health Workers

- Personal Health Navigators
- Birth Doulas
- Peer Support Specialists (including Family Support Specialists, Youth Support Specialists, Recovery Peers, and Mental Health Peers)
- Peer Wellness Specialists
- End-of-Life Doulas

See OHA's Equity and Inclusion Division's webpage bout Traditional Health Workers for more information.

Value-based payment (VBP): A payment structure that is not based on fee-for-service and, instead, rewards services associated with quality and cost-effectiveness rather than volume of services. VBPs are sometimes referred to as Alternative Payment Models (APMs).