Oregon Health Authority
Patient-Centered Primary Care Home Program

2020 Recognition Criteria
Technical Specifications and Reporting Guide

April 2024
Version 5

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 practices that have been recognized by the Oregon Health Authority (OHA) for their commitment to providing high quality, patient-centered care. The PCPCH Program administers the application, recognition, and verification process for practices 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.

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 stakeholders to set the standard for transformative, whole-person, and evidence-based care.

For more information

www.PrimaryCareHome.oregon.gov

PCPCH@oha.oregon.gov

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Introduction

Thank you for your interest in PCPCH recognition for your practice. As a recognized primary care home, your practice can be part of Oregon's vision for better health, better care, and lower costs for all Oregonians.

The Oregon Legislature established the PCPCH Program in 2009. The program works with partners across Oregon to set the standards for what high-quality, patient-centered primary care looks like. The program also identifies primary care homes, promotes their development, and encourages people living in Oregon to seek care through recognized primary care homes.

Patient-Centered Primary Care Homes are health care practices 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:** Practices 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 practices help patients navigate the health care system to get the care they need in a safe and timely way.

- **Patient & 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.

This document represents the most recent version of the PCPCH recognition criteria based on the recommendations of the PCPCH Standards Advisory Committee and input from various partners across Oregon. To learn more about the PCPCH Standards Advisory Committee, please visit the program website at www.PrimaryCareHome.oregon.gov.

The 2020 PCPCH recognition criteria are effective on January 1, 2021. Any practices applying for PCPCH recognition on or after January 1, 2021 must meet the criteria contained in this document.

How to Use the Technical Assistance (TA) Guide

The information and technical specifications in this guide are for practices applying for PCPCH recognition. This guide includes narrative descriptions of the intent of each PCPCH standard, specific definitions, measurement criteria, and example strategies that practices might employ to meet the intent of each standard. The information provided in this guide is not intended as an all-inclusive list of the strategies practices could employ to meet each standard.

For standards that require practices to submit data at the time of application, this guide describes how practices should collect, calculate, and submit this data. For standards that only require attestation at the time of application, this guide describes the information a practice should collect and retain for documentation purposes during verification site visit. Protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations, must be removed or blocked out from the documents, including patient identifiers.

"Best Practice" boxes contain helpful information and suggestions for practices striving to go beyond the checklist and implement best practice approaches. The information contained in the Best Practice boxes are not required for PCPCH recognition or verification purposes.

"Transformation in Practice" boxes contain examples of how practices may approach implementing a specific standard or measure. Practices 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

The PCPCH is Oregon's version of the medical home which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. The PCPCH model represents a road map for providing evidence-based, high-quality comprehensive primary care services. While your practice may "check the box" for meeting certain PCPCH standards, you are encouraged to truly

transform the way things are done 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."*

Practices are also encouraged to think outside the walls of their practice, utilizing a robust health care neighborhood to support the primary care home and their patients. Primary care homes are encouraged to partner with local public health agencies and community organizations to educate and support patients, identify community health priorities, and develop plans to improve the overall health of their communities.

To ensure your primary care home is truly patient-centered, your practice should strive to move beyond the checklist to implement services that are tailored to the specific needs of your patients. To list just a few examples, you could implement plain language communications,[2] ensuring that services are culturally competent and abide by universal precautions for health literacy, or partner with a local organization to have a food truck at your practice that offers fresh fruits and vegetables, or offer yoga or diabetes walking classes at the practice. As your patients' primary care home, you can continuously work to ensure they have what they need for better health and better care. The PCPCH Program is here to support and encourage your practice to begin, or continue, this journey today.

PCPCH Eligibility

Any type of health care practice that provides comprehensive primary care services and has primary care providers is eligible to apply for PCPCH recognition.[3] Practices must be able to report on 12 months of data for their quality and continuity measures, meaning that a practice 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.

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

[2] http://www.plainlanguage.gov/

[3] Specialty practices may apply if they have integrated primary care providers and provide the full range of primary care services outlined in PCPCH Measure 3.B.0.

Practices applying for PCPCH recognition must thoroughly review this guide, including technical specifications, prior to applying. The technical specifications describe each standard in more detail, including what documentation the practice must have to support their attestation. Any standards that a practice attests to or submits data for must be inclusive of and applicable to all clinicians and patient populations at the practice.

> ***Important Note:*** *Practices 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 practice sites, a separate application must be submitted for each site, with data specific to that practice. If all practice 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 practice site. However, standards that require data submission must be calculated and submitted with data specific to each practice site. If you have any questions about your practice's eligibility, please contact us at PCPCH@oha.oregon.gov.

Standards, Scoring Framework, & Tier Levels

The PCPCH model consists of 35 standards which fall under six core attributes of high-quality care—accessible, accountable, comprehensive, continuous, coordinated, and patient & family centered. Practices attest to performing at varying degrees—or "measures"—within each of these standards. There are 11 "must-pass" measures that all practices must attest to (specified in the table on page 11 of this guide). All other measures are valued at different point levels (5-15 points). In addition to meeting all 11 must-pass measures, practices must attest to a minimum of 30 points in order to be recognized as a PCPCH.

Must-pass and 5-point measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon. Measures worth 10 or 15 points reflect intermediate and advanced functions. Each standard is classified as either a "progressive" or a "check all that apply" with regards to the points it is assigned. Within progressive standards, practices 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, practices can attest to meeting multiple measures and add up their points for each one (these standards offer a maximum of 30 points).

The total points accumulated by a practice determines their overall tier of PCPCH recognition. Practices can be recognized at five different tiers depending on the criteria they meet. This tiered structure was created to encourage continued health system improvement within the PCPCH model and to distinguish between practices that meet more measures than others. Tier levels are not, however, intended to be a ranking system for PCPCHs or a report card on a practice's quality of care. For example, a small practice may not have the resources to meet as many measures as a larger practice, but may still be providing top-quality, patient-centered care within their capabilities.

Tier Level	Point Range	Additional Required Criteria
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65 - 125 points	+ All must-pass standards
Tier 3	130 - 250 points	+ All must-pass standards
Tier 4	255 - 430 points	+ All must-pass standards
5 STAR (Tier 5)	255 - 430 points	+ All must-pass standards + Meet 13 out of 16 "5 STAR Measures" + All measures are verified with site visit

COVID-19 Considerations

PCPCH program leaders and staff understand the impact of COVID-19 on our primary care system and have proactively taken steps to ensure that challenges resulting from COVID-19 are considered in the implementation of the PCPCH 2020 recognition standards. PCPCH Program leaders and staff reviewed the PCPCH standards to identify those that may be more difficult for a practice to meet due operational changes or decreased visit volume, among other changes brought about by COVID-19. Throughout this TA Guide there are alternative technical specifications practices may use to meet the intent of the identified standards. These alternative technical specifications are highlighted in the red boxes titled "COVID-19 Considerations."

The PCPCH Standards Advisory Committee reviewed and provided feedback on the alternative technical specifications. PCPCH program staff and/or the PCPCH Standards Advisory Committee will reassess these alternative technical specifications every six months to determine if they are still relevant and if other changes are needed.

Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

5 STAR Designation

Tier 5 in the PCPCH model is a unique designation called 5 STAR. This designation distinguishes exemplary practices that have implemented advanced transformative processes into their workflow using the PCPCH model framework and recommended best practices.

5 STAR designated practices must meet the following criteria:

1. Be recognized as a PCPCH Tier 4 under the 2020 PCPCH Standards
2. Attest to 255 points or more on the practice's most recently submitted PCPCH application
3. Meet 13 or more of the 16 "5 STAR Measures" listed in the table on pages 12-13
4. Receive a site visit to verify they are meeting all PCPCH standards attested to. The designation will not be awarded based on attestation only.

Application Process

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

1. **Read the TA Guide** – Read this guide and have a clear understanding of the intent behind each standard to determine if the practice has the services, policies, and procedures in place to meet the criteria.

2. **Gather required data and documentation** – This guide explains the documentation and/or data that is required for each measure, either at the time of application or in the event that your practice is selected for a verification site visit. The PCPCH Self-Assessment Tool available on the Become Recognized webpage may be helpful in gathering this data and documentation for your practice. It can also help you estimate which tier of recognition you could qualify for based on what standards you meet.

3. **Submit your Application** – Practices must complete and submit their applications electronically through the 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 practice 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.

What to Expect after Your Practice is Recognized as a Primary Care Home

Recognition Renewal Requirements
Your practice's PCPCH recognition is valid for two years from the date of recognition. After two years, you will be required to re-apply for PCPCH recognition to maintain your practice's recognition. Practices are also permitted to re-apply once every 6 months if they wish to increase their tier level or overall point score.

Payment Incentives for Recognized Practices
Oregon is working towards a 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 practice is recognized as a primary care home, there may be payment incentives available from the health plans with which your practice contracts. As of January 2020, Coordinated Care Organizations (CCOs) are required to provide per-member-per-month (PMPM) payments to PCPCH practices in their network as a supplement to any other payments made to PCPCHs, such as fee-for-service or other Value-based Payment (VBP). You are encouraged to contact the health plans and CCOs with which your practice contracts to inquire about payment incentives.

For more information visit the PCPCH Program Payment Incentives webpage.

On-Site Verification

PCPCH Program staff conduct site visits at recognized PCPCHs. The purpose of the on-site verification visits is threefold:

1. Verification that the practice staff and patient experience accurately reflects the standards and measures attested to when the practice was recognized as a PCPCH;
2. Assessment of the care delivery and team transformation process in the practice to understand how the intent of the patient-centered model of care is integrated into the services the primary care home provides; and
3. Collaboration to identify practice needs, barriers to implementation, and areas of improvement needed to help practices successfully implement PCPCH standards. The site visit team helps practices establish improvement plans and connects practices with technical assistance resources 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.[1] By participating in the PCPCH program you are agreeing to an on-site visit by the PCPCH program staff.

This TA Guide explains what documentation a practice must have to support its attestation. The TA Guide also describes how practices should collect and calculate any required data. As your practice prepares to submit a PCPCH application, it is strongly recommended you prepare a binder of documentation to support the application attestation. This documentation binder will be required for each practice selected for a site visit. Protected health information (PHI) must be removed or blocked out from the documents in the binder, including patient identifiers. When your practice 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 practice prepares for the visit.

PCPCH Program Updates

PCPCH Program updates and other relevant information about your practice's recognition is communicated by email. Please sign up to receive PCPCH Program updates at www.govdelivery.com by selecting "PCPCH Updates" among the various subscription options. Please also ensure that the email address you provide in the online PCPCH application is up to date.

Changes at Your Practice

PCPCHs are required to inform the PCPCH Program of any significant changes at their practice. New ownership, practice relocation, change in practice contact information, practice closure, loss of key clinical staff, or other changes should be reported to PCPCH@oha.oregon.gov.

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[1] Oregon Administrative Rule. (2020). Patient-Centered Primary Care Home Program: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1679.

Technical Assistance and Resources

The PCPCH Program provides technical assistance to providers and practice staff as they navigate primary care transformation around the primary care home model. PCPCH program staff are available to answer questions about the PCPCH criteria prior to you applying for PCPCH recognition and provide guidance during the application process. The PCPCH Program website also includes various forms of support on the Resources and Technical Assistance page.

PCPCH program staff provide technical assistance and support on implementation of the PCPCH standards to PCPCHs that receive a verification site visit. During and after a site visit, PCPCH program staff help practices identify needs, barriers, and areas of improvement, as well as connect them with resources to assist in their primary care transformation journey.

The OHA's Transformation Center has technical assistance resources available for clinicians and practice staff working to improve patient care, health outcomes, practice workflows and staff vitality. Topics include adolescent well-care visits, effective contraceptive use, colorectal cancer screening, controlling high blood pressure, tobacco cessation and more. For more information visit Transformation Center Clinic Resources webpage.

NCQA and Oregon PCPCH Recognition

Some practices 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 practice that is already NCQA PCMH certified has the option of submitting an abbreviated paper application instead of the full online application. OHA recognizes NCQA practices according to the criteria below:

- Practices recognized under the **2014** NCQA PCMH criteria can submit an abbreviated paper application and be recognized at the equivalent PCPCH tier level (e.g. a PCMH NCQA Level 3 would be recognized as a PCPCH Tier 3). Alternatively, these practices can submit the full online application and be recognized at the PCPCH tier level that aligns with their points.
- Practices recognized under the **2017** NCQA PCMH criteria can submit an abbreviated application and be recognized as a Tier 4 PCPCH. Alternatively, these practices can submit the full online application and be recognized at the PCPCH tier level that aligns with their points.
- Practices interested in 5 STAR designation must apply with the full online application, regardless of NCQA PCMH recognition.

Depending on the version of NCQA PCMH certification that was achieved, practices seeking PCPCH recognition must attest to and submit additional information as outlined in the table on page 10. NCQA-recognized practices interested in completing an abbreviated PCPCH application can request one by emailing 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 1: Application Requirements for NCQA-recognized PCMHs

Oregon PCPCH Tier Level of interest:	Practices with 2014 NCQA PCMH Recognition *(Practice will be recognized at equal NCQA tier level)*				
	Submit abbreviated paper application	**Submit full online application**	**Provide evidence of NCQA recognition**	**Attest to PCPCH Standard 2.A.0** *(included in both abbreviated and full application)*	**Attest to PCPCH Standard 5.F.0** *(included in both abbreviated and full application)*
Tiers 1 - 3	✓		✓	✓	✓
Tier 4 or 5 STAR		✓		✓	✓

Oregon PCPCH Tier Level of interest:	Practices with 2017 NCQA PCMH Recognition *(Practice will be recognized as a Tier 4 PCPCH)*				
	Submit abbreviated paper application	**Submit full online application**	**Provide evidence of NCQA recognition**	**Attest to PCPCH Standard 2.A.0** *(included in both abbreviated and full application)*	**Attest to PCPCH Standard 5.F.0** *(included in both abbreviated and full application)*
Tiers 1 - 3					
Tier 4	✓		✓	✓	✓
5 STAR		✓		✓	✓

Table 2: The 11 Must-Pass Standards

Practices must meet the 11 Must-Pass measures below in order to be recognized as a PCPCH.

Standard	Must-Pass Measure
Telephone and Electronic Access	**1.C.0** - PCPCH provides continuous access to clinical advice by telephone.
Performance & Clinical Quality	**2.A.0** - PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures. **(D)**
Medical Services	**3.B.0** - PCPCH reports that it routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.
Behavioral Health Services	**3.C.0** - PCPCH has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes.
Personal Clinician Assignment	**4.A.0** - PCPCH reports the percent of active patients assigned to a personal clinician or team. **(D)**
Personal Clinician Continuity	**4.B.0** - PCPCH reports the percent of patient visits with 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 Centers for Medicare and Medicaid Services and includes the following elements: problem list, medication list, allergies, basic demographic information, primary language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.
Specialized Care Setting Transitions	**4.E.0** - PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
End of Life Planning	**5.F.0** - PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.
Meeting Language & Cultural Needs	**6.A.0** - PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their language of choice.
Experience of Care	**6.C.0** - PCPCH surveys a sample of its population on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness.

(D) - *Data submission required with application*

Table 3: 5 STAR Designation Measures

Practices must meet 13 or more of the following 16 measures to qualify for 5 STAR recognition.

Standard	5 STAR Criteria Measures
In-Person Access	**1.A.2** - PCPCH regularly tracks timely access and communication to clinical staff and care teams, and has an improvement plan in place to improve their outcomes.
After Hours Access	**1.B.1** - PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
Alternative Access	**1.G.2** - PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.
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 and/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.
Quality Improvement	**2.D.3** - PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.
Ambulatory Sensitive Utilization	**2.E.2** - PCPCH identifies patients with unplanned or adverse utilization patterns for at least one selected utilization measure and contacts patients, families or caregivers for follow-up care if needed, within an appropriate period of time.
Behavioral Health Services	**3.C.3** - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.
Comprehensive Health Assessment & Intervention	**3.D.3** - PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs.

Personal Clinician Continuity	**4.B.3** - PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.
Medication Reconciliation and Management	**4.G.3** - PCPCH provides Medication Management for patients with complex or high-risk medication concerns.
Care Planning	**5.C.2** - PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs.
Care Planning	**5.C.3** - PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns.
Referral & Specialty Care Coordination	**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.
Referral & Specialty Care Coordination	**5.E.3** - PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social service, foster care (either adult or child), public health, traditional health workers, school-based health center, behavioral health providers and organizations, and pharmacy services.
Meeting Language and Cultural Needs	**6.A.1** - PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic.
Experience of Care	**6.C.2** - PCPCH surveys a sample of its population on their experience of care using one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es). **OR** **6.C.3** - PCPCH surveys a sample of its population on their experience of care using one of the CAHPS survey tools, meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).

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Standard 1.A
In-Person Access

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This is not a must-pass standard. Practices 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 has an improvement plan in place to improve their 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 practice is meeting measure 1.A.1 if it 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." Additionally, the practice regularly shares this data with its entire staff. Examples of items within each category are provided in the table below along with the PCPCH program's recommended targets:

Timely Access to Care: Scheduling Targets		Timely Communication: Response Time Targets	
Routine or follow-up office visit	10 days	Phone hold time for clinician team	10 minutes
Acute office visit	48 hours	Time to return clinical advice calls	4-8 hours
Urgent office visit	24 hours	Time to return portal messages	48 hours
Well Child Check (WCC)	2 months	On-call provider: time to return call	15 minutes
Annual Well Visit (AWV)	3 months	Dropped calls	No dropped calls
No-show appointments	clinic discretion		
Note: *PCPCHs are not limited to the examples listed above. They may choose to set their own targets or track items that aren't in this table provided that they relate to timely access to care or timely communication.*			

Example:
No show appointment slots can be a common, costly, and unaddressed issue that limits provider access for other patients in the practice. To increase open appointment slots, a practice creates a workflow to identify "No-Show" appointments for tracking and reporting purposes. The practice also tracks how quickly the on-call provider returns after-hours calls to patients. It does this 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.

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
2. Documentation demonstrating how and when this data is shared with practice staff, such as:
   o Meeting minutes
   o Presentations
   o White boards
   o Emails

Activities that do not meet 1.A.1:
- The practice only shares reports or data with select staff on the quality team and not the entire staff.
- The practice tracks items for timely access to care but does not track items for timely communication with clinical staff (or vise-versa).

Specifications for 1.A.2

A practice is meeting measure 1.A.2 if it is doing all of 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." Examples of items within each category are provided in the table on page 14.

☑ Regularly shares this data with its entire staff

☑ Has an improvement plan in place to improve outcomes related either to timely access to care or communication with clinical staff and care teams

Example:
Every month, the practice generates reports of patient wait-times on hold and no-show rates. The patient wait-time on hold is already below average, so the quality improvement team focuses on improving patient no-show rates. The practice meets to discuss scheduling, patient access trends, and strategies to reduce its no-show rates. This is shared with the entire staff on a regular basis and helps the practice 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 and care teams
2. Documents showing how this data is shared with staff, such as:
   o Meeting minutes
   o Presentations
   o White boards
   o Emails
3. Documented improvement plan or strategy for how the practice works to improve timely patient access or communication with their clinical staff or care team, such as:
   o Plan, Do, Study, Act cycles
   o Workflow changes
   o Meeting minutes

Activities that do not meet 1.A.2:
- The practice runs reports on its timely access to care or communication with clinical staff and care teams, but it does not share this data with staff and does not have an improvement plan in place to improve outcomes.
- The practice tracks in-person access for two items across the specified categories and finds that they are already performing well on both (their rates are very low). They share this information with staff and decide not to track any other items for which they could develop an improvement plan to increase timely access to care or communication with clinical staff and care teams.

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Standard 1.B
After-Hours Access

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This is not a must-pass standard. Practices 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**

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 ensure that patients, families, and caregivers who work or have other responsibilities during traditional business hours 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 are able to make appointments with their providers (i.e. lunch/administrative hours are not considered as contributing towards the 40 hours)

Specifications for 1.B.1

A practice is meeting measure 1.B.1 if it is consistently open for patients to make appointments with a provider(s) at least 44 hours per week not including lunch/administrative hours. The additional appointment availability must be provided onsite, accessible to the practice's entire patient population, and include access to all of the practice's services including urgent care, acute care, routine preventive and follow-up care.

Examples:
- A practice sees patients for appointments from 8:00am – 5:00pm Monday through Friday and 9:00am – 1:00pm on Saturday.
- A practice see patients for appointments from 7:30am – 7:00pm Monday through Friday.
- A practice is open 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:
- The practice refers patients to an urgent care practice or the emergency department if they need care outside of traditional business hours.
- After-hour visits 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 practice is open at least 4 hours outside traditional business hours but not open for a total of 44 hours per week. For example, the practice is open to patients 8:00am to 6:00pm on Monday through Thursday but closes at noon on Friday.
- The practice 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.

✿ **COVID-19 Considerations**

Practices that have made operational changes or experienced a decrease in patient volume because of COVID-19 may use telehealth to meet the intent of this measure.

Practices only offering acute care or routine preventive care after-hours to mitigate patient and staff risk of exposure to COVID-19 are meeting the intent of this measure as long as the four-hour minimum is met.

Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

Standard 1.C
Telephone & Electronic Access

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

Measure

1.C.0	PCPCH provides continuous access to clinical advice by telephone.	**Must Pass**

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 in their primary language and through accessible communications for individuals with disabilities.

Specifications for 1.C.0

A practice is meeting measure 1.C.0 if it provides all of its patients access to a live person via telephone for clinical advice 24 hours a day, 7 days per week. Additionally, the practice must have documented policies and procedures to ensure that all after-hours telephone encounters are documented in the EHR or paper chart 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 practice 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 practice has a live answering service that triages appropriate business and after-hours phone calls to an on-call clinician.
- The practice contracts with a 24/7 nurse advice line. The nurse advice line sends faxes to the practice with information about patient calls that came in the night before and inputs this information into patients' medical records.

Documentation Required at a Verification Site Visit:
Documentation of after-hours clinical advice from provider to a patient, family member, or caregiver in response to a call that is initiated by the patient

Activities that do not meet 1.C.0:

- The practice 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 practice uses an automated message that refers patients to the emergency room or an urgent care practice during or after business hours.
- The practice uses non-clinical staff (e.g. receptionist) to address medical concerns via phone instead of having real-time access to a clinician.
- The practice 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

One small rural practice 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 practices 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 practices their after-hours notes within 24 hours of the call.

<div align="center">

Standard 1.D
Same Day Access

</div>

This is not a must-pass standard. Practices 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 provides 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 practice 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 practice.[5]

Examples:
- The practice 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.
- The practice ensures each provider in the practice has two AM and two PM templated "Same Day" appointment types every day that they are in practice.

> ⚙ **COVID-19 Considerations**
>
> Practices that have made operational changes or experienced a decrease in patient volume because of COVID-19 may use telehealth to meet the intent of this measure.
>
> Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

Documentation Required at a Verification Site Visit:
Scheduling templates demonstrating same-day appointment availability

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[5] 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.

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.
- Same day appointments are only made available to patients with certain medical needs, rather than being available to the practice's entire patient population.

Standard 1.E
Electronic Access

This is not a must-pass standard. Practices 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.E.1	PCPCH provides patients with access to an electronic copy of their health information.	**5 points**

Intent of Standard 1.E

When surveyed, patients indicate that electronic access to their health information and electronic communication is highly desirable.[6] A primary care home striving to provide access in the form patients prefer should facilitate access to their health information electronically.

Relevant Definitions

"Download": the movement of information from online to physical electronic media

"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

Specifications for 1.E.1

A practice is meeting measure 1.E.1 if its patients can view, download, and transmit their health information online, in a timely manner. 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 practice also offers any other instructions, tools, or materials that patients may need in order to view, download, or transmit their health information.

Health information includes lab test results, problem lists, medication lists, and medication allergy lists. The practice ensures that health information is up to date in the practice'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.

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[6] 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. doi: 10.1197/jamia.M1593

Example:
A practice uses the MyChart feature in their EHR for patients, authorized family members, and caregivers to view records and lab results, ask questions, and request appointments or prescription refills. Daily, the practice responds to requests from patients, families, and caregivers to view items that are not displayed within their MyChart account.

Documentation Required at a Verification Site Visit:
A report or screen shot of the practice's patient portal that demonstrates how patients can view, download, and transmit their health information online in a timely manner

Activities that do not meet 1.E.1:
- Electronic newsletters about the practice
- A website without secure access to protected patient information
- Electronic reminders about patient appointments
- Electronic billing systems

🎖 Best Practice

Meeting Health Literacy Needs

PCPCHs often rely on their EHRs to provide their patients electronic access to their health information. PCPCHs interested in implementing best practices can ensure that electronic health information is available in multiple languages, alternate formats accessible to patients with disabilities,[7] and patients are made aware of the options available. For example, many patient portal interfaces have multilingual functionalities that make them accessible in Spanish and other languages[8] or have features such as large print and contrasted color for visual impairment. In addition to knowing what features help make their EHR more accessible to a diverse range of patients, it is important that PCPCHs consistently communicate these features to their patient population as is applicable to them.

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[7] Resource: Federal Communications Commission (2020): 711 for Telecommunications Relay Service.
[8] Health Information Technology, Evaluation, and Quality Center (2020): Multilingual Patient Engagement Resources.

<h2 style="text-align:center; color:#ED7D31;">Standard 1.F
Prescription Refills</h2>

This is not a must-pass standard. Practices 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 the 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.	**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.[9] 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 practice 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. Practices 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 practice 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.

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[9] Odegard, P. S., & Gray, S. L. (2008). Barriers to medication adherence in poorly controlled diabetes mellitus. The Diabetes Educator, 34(4), 692-697. In this study 21% of the patients indicated that their inability to obtain prescription refills was the cause of their non-adherence to prescribed medical regimens.

- Monthly, the practice conducts a chart audit of at least 30 patient records to determine refill completion times.

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 practice 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 practice is meeting measure 1.F.3 if it is doing all 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. Practices 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).

- ☑ The practice is 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 practice operates with full staff on weekends.

Examples:
- The practice has completed 90% of prescription refills within 48 hours over the last 12 months.

- The practice has increased the percentage of prescription refills completed within 48 hours from 60% to 70% over the last 12 months.
- The practice 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 practice provides data showing that benchmark or improvement is achieved but does not include in the data all prescription refill requests, such as handwritten requests or patients that need to meet with their provider before a medication refill can be authorized.

Standard 1.G
Alternative Access

This is not a must-pass standard. Practices 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 practices activities (max 15 pts):

1.G.1	PCPCH regularly communicates with patients through a patient portal.	**5 points**
1.G.2	PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.	**10 points**

Intent of Standard 1.G

All patients should have the same opportunity to access their provider or care team. Some patients face barriers to in-person, in-practice care and need an alternative to the traditional office visit. Practices that offer alternative office visit types are extending services to patients that may not receive care if only given the option of the traditional office visit.

Relevant Definitions

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

"Qualified health care professional": Physician (MD, DO, ND), Physician Assistant, Nurse or Nurse Practitioner (FNP, RN), Behavioral Health Provider (PhD, PsyD, LCSW, LPC, LMFT,), Care Coordinator, Clinical Pharmacist, Traditional Health Worker, Registered Dietitian or Nutritionist

Traditional in-office visit: face-to-face, billable encounter that results in an evaluation and management of services provided to the patient

Alternative visit type: replaces a traditional in-office visit by interacting with and providing medical decision making for patients through mediums such as telephone appointments, telehealth video appointments, or a face to face visit from a provider in an alternative location such as the patients home or skilled nursing facility

*Medical advice***:** guidance or recommendations from a physician or other qualified health care professional regarding a person's health or wellness

*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)

Specifications for 1.G.1

A practice is meeting measure 1.G.1 if both patients and staff understand the expectations for portal message response times, and how this tool should be used. The practice must have a protocol that sets a standard for portal message response timelines, how the patient is able to utilize the portal, and what type of care they can expect to receive through the portal. The practice needs to share this with patients and staff. The protocol should include standards for acute and non-urgent needs as well as chronic care management standards. The practice needs to demonstrate the use of the patient portal as an alternative type of access to physicians or other qualified health care professionals.

Example:
A practice has a protocol that describes what types of communications and services their patients can access though the portal. It sets standards for a two-hour response time to incoming patient portal messages and lets their patients know that it is not for emergency purposes. They share this 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 responds in a timely manner. When documented in the chart, the practice is able to demonstrate this exchange and how it has improved access to the patient's care team.

Documentation Required at a Verification Site Visit:
1. Examples of how portal usage expectations (scope of medical concerns appropriate for portal messages and timeline for responses to incoming patient portal messages) are shared with patients
2. Examples of two-way communications between patients and physicians or other qualified health professionals, initiated by a patient submitting a medical concern through the portal, and the provider relaying medical advice or care to the patient

Activities that do not meet 1.G.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 reminders, etc.

> While these notifications are important to patient care and useful to send though the portal, this specific measure is focused on access to the care team for two-way communication.

Specifications for 1.G.2

A practice is meeting measure 1.G.2 if it regularly delivers care in at least one way that is an alternative to traditional, office visit-based care and can demonstrate how they have determined this meets the needs of the patient population while increasing access to primary care services. These alternative visits must replace an in-office visit, contain medical decision making, and have a chart note to document the encounter. The following are considered alternative visits:

Alternative locations: Visits at an alternative location such as patients' home, skilled nursing facility, or senior home for the evaluation and management of an established patient, which requires a problem-focused examination and straightforward medical decision making. Typically, 15 minutes are spent face to face with the patient and/or family.

Telemedicine/ Telehealth: The 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. To meet measure 1.G.2 a telehealth visit must 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. The treating provider forwards a summary of the telehealth visit to the patient's primary care physician and communicates with the primary care physician as necessary.

Patient education classes/workshops with individual patient assessment and services: A workshop or class that is facilitated by a provider or qualified health care professional that increases access to primary care for a specific patient population. This group

activity must include individual patient assessment and medical decision making to qualify as an alternative visit. [10]

Examples:
- After receiving feedback from a patient-family advisory council, an internists' office 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. Appointments are listed as such on the schedule or in the chart; "Alternative Visit Type", or "Home/SNF visit."
- A practice administers a survey to help them identify the needs of their patient population. They use the information to start their own diabetes education group class once a week, 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.
- A PCPCH sees a need for behavioral health services but is unable to provide an integrated behavioral health consultant in the practice. They set up an agreement with the local mental health practice to provide telehealth appointments from the PCPCH's office with one of their behavioral health consultants. The PCPCH practice keeps a schedule for these visits, and they are documented in the patient's chart.

Documentation Required at a Verification Site Visit:
1. A policy, procedure, or workflow demonstrating how practice identified patients that would benefit from alternative visit types (e.g. survey results, Patient & Family Advisory Council, comment cards, internal analysis, etc.) and how practice offers alternative visit types for that patient population
2. Examples of chart notes from alternative visits

Activities that do not meet 1.G.2:
- A provider of a practice acts as the medical director at a Skilled Nursing Facility but does not see the practice's assigned primary care patients at this facility.
- A practice offering alternative visit types not based in the assessed needs of their patient population.
- Care coordinator doing care planning with a patient by phone (not all health care professionals are qualified to engage in medical decision-making)
- Health fair with external providers (example: dental/Eye van)
- Offering alternative access activities on a non-regular basis
- External or community group classes or sessions that are not facilitated by a physician or other qualified health care professional and do not involve any individual patient medical decision making.

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[10] **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/workshops that do not involve medical decision making would be considered self-management support (see Standard 6.B) rather than an alternative visit type.

<div align="center">

Standard 2.A
Performance & Clinical Quality

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This is a must-pass standard. Practices 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 practice's activities (max 20 pts):

2.A.0	PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures.	**Must Pass**
2.A.1	PCPCH engages in a Value-Based Payment arrangement with payers covering a significant portion of the clinic population that includes three measures from the set of PCPCH Quality Measures.	**5 points**
2.A.3	PCPCH tracks, reports to the OHA, and demonstrates a combination of improvement and meeting benchmarks on three of the PCPCH Quality Measures.	**15 points**

Intent of Standard 2.A

Measuring and improving clinical quality is a foundational function of PCPCHs. The intent of this standard is to ensure that PCPCHs monitor clinical quality data and utilize this data to improve their performance where appropriate. Value Based Payment (VBP) arrangements can help to incentivize and reward efforts to improve quality such as monitoring selected measures and implementing evidence-based improvement strategies to promote more efficient, effective provision of health care services. It is important that practices monitor clinical quality measures that reflect their patient population.

Relevant Definitions

PCPCH Quality Measures: measures intended to help practices assess and improve the quality of their clinical services. The PCPCH Quality Measure Set is on page 141 of this guide.

Please note that beginning on March 26, 2023 the National Qualify Forum (NQF) is no longer the measure steward for select PCPCH Quality Measures. These specifications are now available through the [Partnership for Quality Measurement](#) (PQM).

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

Specifications for 2.A.0

A practice is meeting measure 2.A.0 if it tracks at least three of the PCPCH Quality Measures[11] and reports its current performance (numerator and denominator) on these measures to the OHA via the PCPCH online application. These quality measures must reflect the practice's entire patient population. For example, Family Practice clinics should monitor both adult and pediatric quality measures. The data collected to calculate performance on these measures must be aggregated across all providers and patients in the practice.

Calculating Current Performance: Each PCPCH Quality Measure has its own specifications/ instructions on how to calculate the numerator and denominator. Practices must use these unique instructions when calculating their own performance. Please see the *PCPCH Quality Measures: Technical Specifications* section of this TA Guide for further details, which begins on page 141.

Accepted Data Collection Methods:
- Querying an electronic medical record system
- Manual audit of an electronic or paper chart (a chart review)
- Quality measures produced from claims data by a 3rd party (e.g. an IPA, health plan, or Comagine Health)[12]

Data Sample Size & Measurement Period: For each quality measure, practices using an EHR query or 3rd party claims data must include in the sample all relevant data from last 6 or 12 months. 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.

> **🏅 Best Practice**
>
> **Conducting a Chart Review**
>
> For more information about setting up an internal audit for practice improvement, self-assessment or submitting data for your PCPCH quality measures, please see the American Academy of Family Physicians resource: [Eight Steps to a Chart Audit for Quality](#).

Practices that do not attest to 2.A.3 are advised to include data from the last 12 months instead of the last 6 months for each quality measure. Practices that attest to both 2.A.0 and 2.A.3 must 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.3.

Documentation Required at a Verification Site Visit:
The data used to calculate the practice's current performance (numerator, denominator, and resulting percentage) for the three selected quality measures

Activities that do not meet 2.A.0
A practice only uses data from the last month to calculate its current performance on its selected quality measures. Practices must include data from the last 6 months or 12 months.

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[11] See section at the end of this Technical Assistance Guide titled "PCPCH Quality Measures."

[12] Practices 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.

Specifications for 2.A.1

A practice is meeting measure 2.A.1 if it has a VBP arrangement with a payer or payers that includes at least three quality measures from the set of PCPCH Quality Measures or other relevant health authorities. The payer(s) that the PCPCH contracts with in the VBP arrangement must cover at least 10% of the practice's patient population. The three quality measures selected must be relevant to the practice's services and patient population.

Documentation Required at a Verification Site Visit:
1. Specific section(s) of current contract(s) with a payer or payers which clearly describes or outlines the VBP arrangement(s), including three or more quality measures. Confidential information in the contract may be redacted.
2. Documentation demonstrating that the payer(s) the PCPCH contracts with in the VBP arrangement cover at least 10% of patient population (e.g. payer mix report, roster of patients, etc.)

Activities that do not meet 2.A.1
A practice has a VBP arrangement with one or more payers, but these do not include at least three quality measures that are relevant to the practice's patient population.

Specifications for 2.A.3

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

☑ Tracks at least three of the PCPCH Quality Measures.

☑ Has improved on at least one of these quality measures (for which it is not yet meeting the benchmark) 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.

The quality measures chosen must be relevant to the practice's patient population. The data collected to calculate performance on these measures must be aggregated across all providers and patients in the practice.

Calculating Current Performance: Each PCPCH Quality Measure has its own specifications/ instructions on how to calculate the numerator and denominator. Practices must use these unique instructions when calculating their own performance. Please see the PCPCH Quality Measures: Technical Specifications section of this TA Guide for further details, which begins on page 141.

Accepted Data Collection Methods:
- Querying an electronic medical record system
- Manual audit of an electronic or paper chart (a chart review)
- Quality measures produced from claims data by a 3rd party (e.g. an IPA, health plan, or Comagine Health)[13]

Data Sample and Measurement Period: For each quality measure, practices using an EHR query or 3rd party claims data must include in the sample all relevant data from last 6 or 12 months. 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.

Note: When demonstrating improvement, the measurement period chosen to calculate the practice'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 the practice reports under 2.A.3 for a given quality measure will match the current performance the practice reports 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).

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

> **Step 1***: Locate the instructions and benchmarks for your selected quality measure.* This can be found in the PCPCH Quality Measures: Technical Specifications section of this TA Guide (beginning on page 141).

> **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 your practice wants to demonstrate improvement over the last 12 months (e.g. January – December *2020*) you would use data from the prior 12 months (i.e. January – December *2019*) to calculate your baseline. If your practice wants to demonstrate improvement over the last 6 months (e.g. July – December *2020*), you would use data from the preceding 6 months (January – June *2020*) to calculate your 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.

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[13] Practices 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.

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

First calculate "X" using the formula below:

$$\frac{[\text{Quality Measure benchmark}] - [\text{clinic baseline}]}{10} = X$$

Then calculate your unique improvement target using the formula below:

$$[\text{clinic baseline}] + [x] = \textbf{Improvement Target}$$

For example, suppose Lady Bug Clinic tracks "Screening for Clinical Depression" as one of their PCPCH quality measures. They calculate their baseline performance on this measure as 56% and see that the benchmark is 63%. They would calculate their improvement target as:

$$\frac{63 - 56}{10} = 0.7 \qquad 56 + 0.7 = \boxed{56.7\%}$$

Step 4: *Compare improvement target to your current performance.* To calculate your practice's current performance, you must use data from the most recent 6 or 12 months and the measurement period must be equal to that used for your baseline. For example, if you used 12 months of data from 2019 to calculate your baseline, you must use 12 months of data from 2020 to calculate your current performance. If your practice's current performance meets or surpasses your practice's improvement target, you have successfully demonstrated improvement in this quality measure.

Documentation Required at a Verification Site Visit:
1. The data used to calculate the practice's current performance (numerator, denominator, and resulting percentage) for the three selected quality measures
2. The data used to calculate the practice's baseline(s) and improvement target(s) for the quality measure(s) that the practice has chosen to demonstrate improvement; if the practice chooses to demonstrate improvement over the last year, it will need to show 2 years of data. If the practice 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.3
A practice meets the benchmark for all three quality measures rather than selecting a quality measure for which it is not yet meeting the benchmark to demonstrate improvement.

> 🎖 **Best Practice**
>
> **Improving Health Equity**
> In order ensure that quality improvement activities benefit all patients in a diverse patient population, a best practice for a PCPCH is to stratify their quality measure performance by race, ethnicity, primary language, and disability to identify any potential disparities. A PCPCH can then use this information to help implement quality improvement strategies to reduce any identified health inequities.

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Standard 2.B
Public Reporting

</div>

This is not a must-pass standard. Practices 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

2.B.1	PCPCH participates in a public reporting program for performance indicators and data collected for public reporting programs is shared with providers and staff within the PCPCH.	**5 Points**

Intent of Standard 2.B

Opportunities for PCPCHs to make health care quality and outcomes data publicly available are on the rise. In addition to increasing transparency and public awareness, public reporting provides data that translates into goals or targets on quality improvement and practice growth. This standard helps ensure that practices leverage opportunities to make data publicly available and refrain from opting out of these initiatives.

Relevant Definitions

Public Reporting Program: an organization that collects and publishes data publicly to a broad audience, free of charge, on the quality of care offered by healthcare providers to help patients remain informed about their healthcare

Specifications for 2.B.1

Comagine Health (formerly the Oregon Health Care Quality Corporation or "Q Corp") is currently the only public reporting program available in Oregon that meets the specifications for this measure. A practice is meeting measure 2.B.1 if it participates in the Comagine public reporting program and regularly shares the reported metrics data with all practice staff in order to evaluate performance and direct quality improvement activities. Claims-based quality measures results for primary care practices are updated annually and publicly reported through Comagine's "Compare your Care" portal.[14]

Practices with 3 or more primary care providers are automatically enrolled in the program, and measure denominators with at least 30 patients and whose groups have been included in at least one round of Comagine reports are automatically publicly reported. Practices with fewer

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[14] Comagine Health (2017). Compare Your Care: http://q-corp.org/compare-your-care.

than three primary care providers do not have their scores reported on the public website, but they may opt-in to public reporting by contacting Comagine.[15]

To date, results for individual providers have not been publicly reported. However, they are provided online through the reporting portal for practice/provider use and quality improvement purposes.[16]

Quality scores are computed using claims data from voluntarily participating health plans. Averages for Oregon practices are compared to the National Committee for Quality Assurance (NCQA). Quality scores are computed using claims data from voluntarily participating health plans.

Documentation Required at a Verification Site Visit:
1. A report or dashboard from a public reporting program that is available to the public through a website, or publication
2. Examples of communications, posters, or meeting minutes demonstrating how this data is shared with all clinicians and staff

Activities that do not meet 2.B.1
- A practice shares data on the Compare your Care portal but does not share this with its staff and clinicians.
- A practice shares performance data with its patients (e.g. hanging up a poster with clinic-level data in the patient waiting room) but does not make it available on a public reporting site (e.g. does not participate in Compare Your Care).
- A practice participates in mandated reporting programs that only apply to a subset of its patients, such as infectious disease reporting, CCO metrics, or other payor reporting programs.

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[15] Email is info@q-corp.org and the Public Reporting Opt-in Request Form can be found at http://www.q-corp.org/sites/default/files/Public%20Reporting%20Opt-In.pdf
[16] Comagine Portal: www.q-corp.org/portal

Standard 2.C
Patient & Family Involvement in Quality Improvement

This is not a must-pass standard. Practices 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, and/or educational improvement activities.	**10 points**
2.C.3	Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	**15 points**

Intent of Standard 2.C

While all practices aspire to be responsive to the needs of their patients, formalizing the involvement of diverse patients, families, and caregivers in quality improvement efforts increases a practice's ability to be responsive to their needs. While quality improvement is implicit to several other standards, these measures provide a roadmap for practices to engage diverse patients, families, 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 practice, among other characteristics

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

Specifications for 2.C.1

A practice is meeting measure 2.C.1 if it has convened a group of diverse patients, families, and/or caregiver advisors at least once within the last 12 months to provide feedback and

guidance on how the practice can improve on a specific area of focus. The practice must document the guidance gathered during this advisory process.

Examples:
- The practice hosts a meeting in which a diverse group of patients, families, and caregiver advisors review and provide feedback on materials before they are distributed to the practice's patient population. The practice documents the materials they present to the group, and how they use the group's feedback in their quality improvement activities.
- The practice convenes a diverse group of patients, families, and caregiver advisors to assess waiting room and front office processes. The practice documents what changes are made to their waiting room and front office processes based upon the group's input.

Documentation Required at a Verification Site Visit:
Transcripts from at least one 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. The meeting must be convened by the individual practice with patients, families, and caregiver advisors who receive care at the individual practice.
- The practice only uses feedback from a patient survey for quality improvement activities. They do not convene a group of patients, families, and caregiver advisors that come together to meet and interact with one another.

Specifications for 2.C.2

A practice is meeting measure 2.C.2 if it continually involves patients, families, and caregiver advisors as members of ongoing quality improvement, safety, and/or program development activities at the practice.[17]

Examples:
- In order to help enhance patience experience among their patients, a practice maintains a diverse patient, family, and caregiver advisory council that routinely reviews practice data and quality improvement efforts for their advice and guidance.

> ⚙ **COVID-19 Considerations**
>
> Practices that have made operational changes because of COVID-19 can meet the intent of this measure by using virtual technologies (e.g. Zoom, phone calls, etc.) to engage with patients.
>
> Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

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[17] Resource: Institute for Patient- and Family-Centered Care. (2013). Partnering with Patients and Families to Enhance Safety and Quality: A Mini Toolkit.

- A practice forms an on-going quality improvement committee made up of its own patients, family members, and caregivers from a variety of ages and medical conditions. The team brainstorms solutions to challenges patients face in using the patient portal, which it monitors and evaluates over a year in efforts to make the portal more accessible for all.

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

★ **Transformation in Practice**

Involving Patients, Families, and/or Caregivers in Quality Improvement

A pediatric practice 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 practice helped parents learn how to navigate the complex health system together, ensure their children received the care that they needed, and provide emotional support to one another.

Activities that do not meet 2.C.2:

- The practice 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.

Specifications for 2.C.3

A practice is meeting measure 2.C.3 if it is doing all of the following:

☑ It continually involves patients, families, and caregiver advisors as members of ongoing quality improvement, safety, and/or program development activities at the practice (see 2.C.2 specifications for examples).

☑ It has patients, families, and/or caregiver advisors who are integrated into the practice and have defined roles in administration or patient care (such as providing peer support to patients or assisting in the training/hiring of practice staff). There must be an established process for recruiting, training, and supporting diverse patient, family, and

caregiver advisors. Their training should include topics such as HIPAA and signing of a confidentiality statement, safety, infection control, etc. Additionally, the practice tracks information on patient advisory positions such as identified positions, services provided, hours worked, and performance evaluations.

Examples:
- In addition to having a patient advisory council that meets monthly, a practice has integrated patients, families, and caregiver advisors who regularly participate in staff training or hiring activities such as interviewing potential new employees.
- A practice 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 practice.
- In addition to a patient advisory group, a practice has volunteers who welcome new patients as they walk into the practice, give out new patient orientation packets, and help answer any questions new patients may have. The volunteers also provide the practice 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 patients, families, and/or caregivers are integrated into the practice (examples of practice staff trainings and peer support activities assisted/facilitated by integrated patient advisors)

> ⚙ **COVID-19 Considerations**
>
> Practices that have made operational changes because of COVID-19 can meet the intent of this measure by using virtual technologies (e.g. Zoom, phone calls, etc.) to engage with patients.
>
> Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

Activities that do not meet 2.C.3:
Patients, families, and caregiver advisors are highly engaged with on-going quality improvement efforts, but they do not have defined roles in administration or patient care (e.g., hiring or training practice staff, facilitating peer-support groups).

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Standard 2.D
Quality Improvement
</div>

This is not a must-pass standard. Practices 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 multidisciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and document 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 practice. 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

Having a formal quality improvement (QI) program is an essential component of PCPCHs.[18] 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 critical to efficiently collect, analyze, and act on data to improve quality of care.

Relevant Definitions

Performance Data: data collected using standardized processes in order to assess a practice's performance with regards to a service or health outcome. Performance data may be collected

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[18] Medicare Payment Advisory Commission (MEdpAC). (2008). Report to Congress: Reforming the Delivery System.

from health records, surveys, EHR dashboard reports, care gap lists, staff feedback, and other methods[19]

Multi-disciplinary: staff from multiple roles at the practice – including providers, support staff, management, and front desk staff

Specifications for 2.D.1

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

Examples:
- A practice 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 practice documents the different PDSA steps to guide their ongoing project decisions.
- A practice wants to decrease the number of patients that have a high blood pressure reading at the time of their appointment. They decide to use SMART goals (Specific, Measurable, Achievable, Realistic, and Timely) 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 practice documents each specific action it takes towards its SMART 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 practice 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.

Specifications for 2.D.2

A practice is meeting measure 2.D.2 if it has implemented a multi-disciplinary quality improvement team that regularly (minimum of 8 times per year) reviews data and plans, documents, and implements improvement activities in the practice.

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

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[19] See the Institute for Healthcare Improvement's (2020) Science of Improvement: Establishing Measures for tips on designing measurement.

Examples:
- A practice has a QI committee that meets regularly to implement PDSA cycles and has representation from every practice role and department. The practice documents the progress on each improvement project it is implementing and presents the results to staff.
- A small practice 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 practice participate on a QI committee at an organizational or health system-wide level, but they do not define quality improvement initiatives specific to their practice or their patient population.

Specifications for 2.D.3

A practice is meeting measure 2.D.3 if it has implemented a multi-disciplinary quality improvement team that regularly (8-12 times per year) reviews data, plans improvement activities, documents progress, and has a clinic-wide annual improvement strategy with performance goals. Improvement strategy performance goals should be derived from: community, patient, family, caregiver, and other stakeholder feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice.

Examples:
- A practice develops an annual clinic-wide improvement strategy that includes a proactive timeline integrating multiple improvement projects based in SMART 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 practice has a quality team who regularly meets to review, plan, and document the progress of their improvement activities.
- A practice 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 practice.
- A practice is part of a large health system that has a system-wide quality improvement plan for its multiple clinics. The practice 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 practice 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 performance goals derived from community, patient, family, caregiver, and other stakeholder feedback. The improvement strategy goals should also include input from publicly reported measures, as well as areas for operational improvement that are identified by the practice. The improvement strategy includes a monitoring and evaluation methodology, multiple improvement related projects, and methods of communication to gather, learn, and apply best practices. It must include forward facing goals.
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

Activities that do not meet 2.D.3:
- A collection of past QI projects without a standardized monitoring or evaluation methodology and/or demonstration of how the projects support the overall annual strategic QI goals.
- Extensive metrics tracking and reporting without an annual improvement strategy to identify areas of focus, annual goals and evidence of structured improvement projects.
- An annual strategic plan with strategies and goals that are defined and based solely on incentive metrics that are prioritized by a CCO or payer.
- An annual strategic plan that only accounts for CCO patients or another population subset and is not applied to the practice's entire patient population.

⊗ Best Practice

Improving Health Equity

PCPCHs interested in implementing best practices can work to ensure that improvements are benefitting all their diverse patients. Practices can stratify their quality measure performance by race, ethnicity, primary language, disability, and other factors to identify any potential disparities. They can then develop and implement specific quality improvement goals and strategies to reduce any identified disparities.

Standard 2.E
Ambulatory Sensitive Utilization

This is not a must-pass standard. Practices 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 practice's activities (max 30 pts):

2.E.1	PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure.	**5 points**
2.E.2	PCPCH identifies patients with unplanned or adverse utilization patterns for at least one selected utilization measure and contacts patients, families or caregivers for follow-up care if needed, within an appropriate period of time.	**10 points**
2.E.3	PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure.	**15 points**

Intent of Standard 2.E

PCPCHs play a critical role in "bending the cost curve" by ensuring that ambulatory conditions are treated well, to the patients' satisfaction, and in the most cost-effective setting. Timely, high-quality, actionable data is important for helping practices target areas for improvement. Value Based Payment (VBP) arrangements can help to incentivize and reward work that optimizes utilization such as monitoring selected measures and implementing evidence-based improvement strategies that promote more efficient and effective health care utilization.

Relevant Definitions

PCPCH Utilization Measures: measures selected by the PCPCH Program to help practices assess their patient population's utilization of healthcare services and use this information to inform efforts to reduce adverse or avoidable utilization patterns (such as hospital admissions, ED visits, etc.) among their patients. These measures are drawn from various national and state health authorities. The full list of PCPCH Utilization Measures begins on page 52 of this guide

Value-Based Payment (VBP) arrangement: a payer-clinic arrangement specifying a payment structure that is not based on fee-for-service and instead rewards services associated with

quality, utilization, and cost-effectiveness rather than volume of services. VBPS are sometimes referred to as Alternative Payment models (APMs)

Specifications for 2.E.1

A practice is meeting measure 2.E.1 if it has a VBP arrangement with a payer or payers that includes at least one PCPCH Utilization Measure or a utilization measure from another relevant health authority. The payer(s) that the PCPCH contracts with in the VBP arrangement must cover at least 10% of the practice's patient population. The utilization measure(s) chosen must be relevant to the practice's services and patient population.

Documentation Required at a Verification Site Visit:
1. Specific section(s) within current contract(s) with a payer or payers which clearly describes or outlines the VBP arrangement(s), including at least one utilization measure. Confidential information in the contract may be redacted.
2. Documentation demonstrating that the payer(s) the PCPCH contracts with in the VBP arrangement cover at least 10% of patient population (e.g. payer mix report, roster of patients, etc.)

Activities that do not meet 2.E.1:
A practice has a contract with one or more payers that includes a VBP arrangement, but the contract does not include a utilization measure that is relevant to the practice's patient population.

Specifications for 2.E.2

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

☑ Tracks at least one of the PCPCH Utilization Measures among its patient population. **Note:** For 2.E.2 only, practices may choose to use their own specifications instead of those provided by the OHA or original measure steward as long as they relate to the measure and include all patients in the calculations (e.g. not just CCO 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. The practice's policy must define the appropriate contact period and include a process for documenting that systematic follow-up was completed in a log. When contacting patients, the practice 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 physician counseling, 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/case management and self-management support programs outside of the practice.

Example:

A practice tracks utilization patterns for the measure "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 practice contacts patients, families, and/or caregivers via phone, patient portal, or letters.

Documentation Required at a Verification Site Visit:
1. Documentation demonstrating that the practice is routinely tracking one or more of the PCPCH Utilization Measures
2. Policies, procedures, or workflow for tailoring interventions (such as care coordination) for patients with unplanned or adverse patterns in the PCPCH Utilization Measure being tracked
3. Examples from the medical record showing that the practice contacts these patients, families, and/or caregivers to evaluate their status and to make a follow-up appointment or facilitate other appropriate interventions

> **🎗 Best Practice**
>
> **Reducing Health Disparities**
> In order to ensure that improvements in ambulatory sensitive utilization are benefitting all of a practice's diverse patients, PCPCHs interested in implementing best practices can stratify their utilization measure performance by race, ethnicity, primary language, and disability to identify any potential disparities. They can then develop and implement quality improvement strategies to reduce any identified disparities.

Activities that do not meet 2.E.2
- The practice infrequently tracks or conducts an ad hoc review of selected PCPCH Utilization Measures.
- The practice inconsistently contacts patients with high utilization patterns and does not have a clinic-wide strategy or policy in place to help improve utilization patterns.

Specifications for 2.E.3

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

☑ Tracks at least one of the PCPCH Utilization Measures among its patient population.

☑ Either meets the benchmark on its selected PCPCH Utilization Measure(s) or has improved on at least one of the measures (for which it is not yet meeting the benchmark) in the last 6 or 12 months.

The utilization measure(s) the practice selects must be relevant to its patient population. The data collected to calculate performance on these measures must be aggregated across all providers and patients in the practice.

Calculating Current Performance:

Links to the specifications and benchmarks for each PCPCH Utilization Measure are provided in the table on pages 52-54 of this guide. Practices may calculate their numerator and denominator using the specifications provided by either the original measure steward or the OHA. *Note:* Practices that use the specifications provided by the OHA rather than the original measure steward must include all their patients in their calculations, not just patients who are CCO members.

Accepted Data collection methods:

- Querying an electronic medical record system or health information exchange
- Manual audit of utilization data available in EHR or health information exchange
- Utilization measures produced from claims data by a 3rd party (e.g. an IPA, health plan, or Comagine Health)[20]

Data Sample and Measurement Period: For each utilization measure, practices using an EHR or health information exchange query or 3rd party claims data must include in the sample all relevant data from last 6 or 12 months. 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.

Demonstrating Improvement:

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

> **Step 1***: Locate the instructions and benchmarks for your selected utilization measure.* Links to the specifications/instructions for each measure, along with their baselines, can be found in the PCPCH Utilization Measures table beginning on page 52 of this guide.

> **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 the practice wanted to demonstrate improvement over the last 12 months (e.g. January – December 2020) it would use data from the prior 12 months (i.e. January – December *2019*) to calculate its baseline. If the practice wanted to demonstrate improvement over the last 6 months (e.g. July – December 2020), it would use data from the preceding 6 months (January – June 2020) to calculate its baseline.

> **Step 3:** *Calculate your unique improvement target.* First calculate "X" using the formula below:

$$\frac{[\text{Utilization Measure benchmark}] - [\text{clinic baseline}]}{10} = \textbf{X}$$

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[20] Practices that submit utilization 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.

Then calculate your unique improvement target using the formula below:

$$[\text{clinic baseline}] + [x] = \textbf{Improvement Target}$$

For example, suppose Lady Bug Clinic tracks "Follow Up after Mental Health Hospitalization" as their PCPCH utilization measure. They calculate their baseline performance on this measure as 44% and see that the benchmark is 54%. They would calculate their improvement target as:

$$\frac{54 - 44}{10} = 1$$

$$44 + 1 = \boxed{45\%}$$

Step 4: Compare improvement target to your current performance. To calculate your current performance, you must use data from the most recent 6 or 12 months and the measurement period must be equal to that used for your baseline. For example, if you used 12 months of data from 2019 to calculate your baseline, you must use 12 months of data from 2020 to calculate your current performance. If your current performance meets or surpasses your improvement target, you have successfully demonstrated improvement in this utilization measure.

Documentation Required at a Verification Site Visit:
1. The data used to calculate the practice's current performance (numerator, denominator, and resulting percentage) for its selected PCPCH Utilization Measure(s)
2. If practice does not meet the benchmark: the data used to calculate the practice's baseline(s) and improvement target(s). If the practice has chosen to demonstrate improvement over the last year, they will need to show 2 years of data. If the practice has chosen to demonstrate improvement over the last 6 months, they will need to show one year of data.

Activities that do not meet 2.E.3
Practice does not meet benchmark or is not able to demonstrate improvement in its selected utilization measure.

PCPCH Utilization Measures

Measure Name	Measure Description & Specifications[21]	Benchmark[22]
Plan All-Cause Readmission	*Description:* Number of acute inpatient stays for patients 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. *Specifications:* NCQA specifications *(official measure steward)*: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/ OHA specifications *(from State Quality Measures)*: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Plan-All-Cause-Readmission-2017.pdf	**0.6352**
Follow up after Mental Health hospitalization	*Description:* Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within (1) 30 days and (2) 7 days after discharge. *Specifications:* NCQA specifications *(official measure steward)*: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/ OHA specifications *(from CCO Incentive Measures)*: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-specs-(Follow-up-after-MH-hospitalization)-final.pdf	30 days post discharge: **54%**
Total Resource Use Population-based PMPM Index	*Description:* The Resource Use Index (RUI) is a risk-adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. *Specifications:* HealthPartners specifications *(official measure steward)*: https://p4qm.org/measures/1598	**TBD**

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[21] Please refer to either the original measure steward or the OHA CCO Incentive Measure links for the specifications. **Note:** For 2.E.2 and 2.E.3, practices that use the specifications provided by the OHA rather than the original measure steward MUST include all of their patients in their calculations, not just their patients who are CCO members.

[22] Practices using the OHA CCO Incentive Measures specifications rather than the original measure steward may use the associated OHA benchmarks.

Measure Name	Measure Description & Specifications[21]	Benchmark[22]
Follow-up After ED Visit for Mental Illness	*Description:* Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness who received a follow-up visit for mental illness within (1) 30 days and (2) 7 days of the ED visit. *Specifications:* NCQA specifications *(official measure steward)*: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/	30 days post ED visit: **57%**
Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence	*Description:* Percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow-up visit for AOD within (1) 30 days and (2) 7 days of the ED visit. *Specifications:* NCQA specifications *(official measure steward)*: https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence/	30 days post ED visit: **22%**
Cesarean Rate for Nulliparous Singleton Vertex	*Description:* Percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. *Specifications:* The Joint Commission specifications *(official measure steward)*: https://manual.jointcommission.org/releases/TJC2020A1/MIF0167.html	**TBD**

[21] Please refer to either the original measure steward or OHA CCO Incentive Measure links for the specifications. **Note:** For 2.E.2 and 2.E.3, practices that use the specifications provided by the OHA rather than the original measure steward MUST include all of their patients in their calculations, not just their patients that are CCO members.

[22] Practices using the OHA CCO Incentive Measures specifications rather than the original measure steward may use the associated OHA benchmarks.

Measure Name	Measure Description & Specifications[21]	Benchmark[22]
Prenatal & Postpartum Care	*Description:* The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. *Specifications:* NCQA specifications *(official measure steward)*: https://p4qm.org/measures/1517 OHA specifications *(from CCO Incentive Measures)*: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-2021-specs-(Prenatal-Postpartum-Care)-20201222.pdf	PCC Prenatal: **TBD** PCC Postpartum: **61 %**
Ambulatory Care	*Description***:** NCQA retired this measure in 2020. The PCPCH program will be adding a replacement Ambulatory Care measure in the next iteration of the model. ***For now, practices may track Ambulatory Care to meet 2.E.2 only.*** This would entail tracking the number of ED visits/discharges among their patient population. *Additional Guidance:* OHA specifications *(from CCO Incentive Measures)*: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Ambulatory-Care-Outpatient-ED-Utilization.pdf	**NA**

[21] Please refer to either the original measure steward or OHA CCO Incentive Measure links for the specifications. **Note:** For 2.E.2 and 2.E.3, practices that use the specifications provided by the OHA rather than the original measure steward MUST include all of their patients in their calculations, not just their patients that are CCO members.

[22] Practices using the OHA CCO Incentive Measures specifications rather than the original measure steward may use the associated OHA benchmarks.

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Standard 2.F
PCPCH Staff Vitality

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This is not a must-pass standard. Practices 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 uses a structured process to identify opportunities 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 practice staff may positively influence the quality of life for everyone at the primary care home, including patients.

Relevant Definitions

Vitality: the state of being strong and active in energy, morale, and/or within physical, mental, and emotional realms

Specifications for 2.F.1

A practice is meeting measure 2.F.1 if it is able to define its ongoing strategy for addressing staff vitality, including:

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

Example:
All employees of a practice are offered the opportunity to provide input. The practice uses an employee satisfaction survey to measure stress management needs and gather team-building

suggestions from staff. Leadership shares 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 practice 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 practice gathers feedback from staff
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 practice does not share the results with the entire staff.
- The practice does not implement any activities that address staff vitality based on their feedback.

Specifications for 2.F.2

A practice is meeting measure 2.F.2 if it is able to define its ongoing strategy for addressing staff vitality, including:

- ☑ The methods the practice uses to gather feedback from all employees, to be completed at least once a year
- ☑ How results are shared with entire staff (e.g., email, internal newsletter, all-staff meetings)
- ☑ Actions taken by the practice that directly impact staff vitality, based on the employee feedback
- ☑ How these actions or activities are monitored/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 practice makes a few changes in the workflow, and after three months ask for more anonymous feedback from the staff to see if these changes have affected the team's morale.
- A practice conducts focus groups within all departments to discuss how the physical environment, due to new construction, could be more conductive to employees' well-being. It summarized feedback at an all-staff meeting and generated 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 may have - including how new technology could be utilized. The practice's leadership seeks employee feedback to intentionally improve or maintain staff vitality.
- A practice uses monitoring/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 practice gathers feedback from staff
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

Activities that do not meet 2.F.2:
Practice 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 very high (on a scale of 1-10), a practice implements new workflows to streamline how they coordinate case management for patients. However, the practice 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 practice has not measured the actual impact on staff vitality.

Standard 3.A
Preventive Services

This is not a must-pass standard. Practices 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 preventive services appropriate for its population (i.e., age and gender) based on best available evidence, and identifies areas for improvement.	**5 points**
3.A.2	PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services and has an improvement strategy in effect to address gaps in preventive service offerings as appropriate for the PCPCH patient population.	**10 points**
3.A.3	PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate 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 gender appropriate 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 Gender Appropriate Preventive Services

The age and gender appropriate services that meet the intent of Standard 3.A are based on best available evidence. They include:
- USPSTF Grade A and B recommendations[23]
- *Bright Futures* Recommendations for Pediatric Preventive Health Care[24]
- ACIP recommended vaccinations[25]
- HRSA-recommended preventive services for women[26]

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[23] U.S. Preventive Services Task Force (2020): A and B grade Recommendations.
[24] Bright Futures (2020): Clinical Practice Guidelines.
[25] Center for Disease Control and Prevention (2020): Vaccine-Specific ACIP Recommendations.
[26] Health Resources & Services Administration (2019): Women's Preventive Services Guidelines.

- Recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children[27]
- Standards of Care for Children and Youth with Special Health Care Needs Pediatric and Primary Care [28]

Specifications for 3.A.1

A practice is meeting measure 3.A.1 if it routinely offers or coordinates each of the four types of recommended age- and gender-appropriate 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 & 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"[29] to review expected patient-specific care needs

> **🎗 Best Practice**
>
> **Evidence-Based Preventive Care**
>
> If your practice 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.

Example:
A health care team member or dedicated care coordinator is responsible for the provision and coordination of preventive services for the practice'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.

Documentation Required at a Verification Site Visit:
Policies, procedures, or workflow that includes how patients due for preventive services are proactively identified

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[27] Health Resources & Services Administration (2018): Recommended Uniform Screening Panel.
[28] Association of Maternal & Child Health Programs (2014): Standards for Systems of Care for Children and Youth with Special Health Care Needs.
[29] Spectrum Health Medical Group (2010): Spectrum Health Medical Group Morning Huddles. *Youtube*.

Activities that do not meet 3.A.1
- Practice does not have pre-visit planning processes and is unable to determine which age-appropriate preventive services a patient is due for.
- Practice does not ensure that screenings are performed on a regular basis as recommended based on gender.

Specifications for 3.A.2

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

☑ Routinely offers or coordinates each of the four types of recommended age- and gender-appropriate 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 gender-appropriate 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 practice 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 practice has a documented strategy to identify and close care gaps in preventive services such as colonoscopy.
- A practice 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 practice uses this clinical information to identify patients in need of cervical cancer screening, breast cancer screening, and prostate cancer screening. The practice develops a documented strategy based on the most current recommendations to increase the needed screenings among these patients.[30]

Documentation Required at a Verification Site Visit:
1. Policies, procedures, or workflow that includes how patients due for preventive services are proactively identified
2. An improvement plan that contains all required elements listed in the specifications

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[30] There are several resources available describing best practice clinical guidelines for transgender patients, including gender-appropriate and gender-affirming services and procedures. These include the National LGBTQIA+ Health Education Center's (2018) Learning Modules: Behavioral Health Care for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) People and University of California, San Francisco's (2016) Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.

Activities that do not meet 3.A.2:
- The practice only tracks care gaps for a sub-section of patients based on payer type.
- The practice does not have an improvement strategy for preventative service gaps in care.

Specifications for 3.A.3

A practice is meeting measure 3.A.3 if it is offering or coordinating 90% of the recommended preventive services appropriate for its patient population. If the practice 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 62-64 of this guide.

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

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

Example:
A pediatric practice 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. Policies, procedures, or workflow that includes how patients due for preventive services are proactively identified
2. List of age- and gender-appropriate preventive services offered and applicable calculation to demonstrate meeting the 90% threshold

Activities that do not meet 3.A.3:
A practice 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

Recommended Service	Source	Sub-population	To be completed by PCPCH:	
			Applicable	Offered
Abdominal Aortic Aneurysm	USPSTF	Men age 65-75 who have ever smoked		
Age Appropriate Anticipatory Guidance	BF	Children		
Anxiety Screening	HRSA	Adolescents, Adults (including pregnant and postpartum women)		
Alcohol Misuse Counseling	USPSTF , BF	Adolescents, Adults		
Anemia Screening	BF	Children		
Aspirin to prevent CVD	USPSTF	Adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk		
Autism Screening	BF	Children		
Bacteriuria Screening	USPSTF	Pregnant women		
BRCA Screening and Counseling	USPSTF	Women with a personal or family history of breast, ovarian, tubal or peritoneal cancer		
Breast Cancer Chemoprevention	USPSTF	Women at high risk for breast cancer		
Breastfeeding Interventions and Supplies	USPSTF, HRSA	Pregnant and postpartum women		
Cervical Cancer Screening	USPSTF, HRSA	Adult women age 21 years or older		
Chlamydial Infection Screening	USPSTF	Women		
Colorectal Cancer Screening	USPSTF	Adults age 50-75 years		
Comprehensive Newborn Screening	BF, HRSA	Newborns		
Contraceptive Methods and Counseling	HRSA	Adolescents, Adult		
Dental Caries Prevention	BF, USPSTF	Infants, Children		
Depression Screening	BF, USPSTF	Children, Adolescents and Adults including pregnant and postpartum women		

Developmental Surveillance and Screening	BF	Children		
Diabetes Mellitus and Abnormal Blood Glucose Screening	HRSA, USPSTF	Adults aged 40 to 70 years who are overweight or obese		
Fall Prevention	USPSTF	Adults age 65 years or older		
Fluoride Chemoprevention	USPSTF	Children		
Folic Acid Supplementation	USPSTF	Pregnant women		
Gestational Diabetes Screening	HRSA, USPSTF	Pregnant women at or after 28 weeks gestation		
Gonococcal Ophthalmia Prophylaxis	USPSTF	Newborns		
Gonorrhea Screening	USPSTF	Women		
Health Diet and Physical Activity Counseling	HRSA, USPSTF	Adults with cardiac risk factors		
Hearing Screening	BF, USPSTF	Newborns		
Hepatitis B Screening	USPSTF	Pregnant women		
Hepatitis C Screening	USPSTF	High risk adults, one-time screening for adults born from 1945 to 1965		
High Blood Pressure Screening	USPSTF	Adults		
HIV Pre-exposure Prophylaxis	USPSTF	High risk adults		
HIV Screening	BF, HRSA, USPSTF	Pregnant women, High risk adolescents and adults		
HPV Testing	HRSA	Adult women		
Iron Supplementation	USPSTF	Pregnant women		
Lung Cancer Screening	USPSTF	High risk adults ages 55 to 80 years		
Lead Screening	BF	At-risk children		
Mammography	HRSA, USPSTF	Women		
Obesity Screening and Counseling	BF, USPSTF	Children, Adolescents, Adults		
Oral Health Risk Assessments	BF	Children		
Osteoporosis Screening	USPSTF	Women 65 years or older, at-risk post-menopausal younger women		
Perinatal Depression Counseling and Interventions	USPSTF	Pregnant and postpartum women		

Preeclampsia Prevention: Aspirin	USPSTF	Pregnant women gestational age at of greater than 12 weeks		
Preeclampsia Screening	USPSTF	Pregnant women		
Routine Vaccination	BF, ACIP	Children, Adults		
Screening and Counseling for Interpersonal and Domestic Violence	BF, HRSA, USPSTF	Adolescents, Women		
Screening for Urinary Incontinence	HRSA	Women		
Skin Cancer Behavioral Counseling	USPSTF	Adolescents, young adults, parents of young children		
Statin Preventive Medication	USPSTF	Adults 40 to 75 years		
Sexually Transmitted Infection Counseling	BF, HRSA, USPSTF	Adolescents, Adults		
Syphilis Screening	USPSTF	Adolescents, Adults		
Tobacco Use Counseling and Interventions	BF, USPSTF	Adolescents, Adults		
Tuberculosis Screening	BF, USPSTF	At-risk children and adults		
Unhealthy Alcohol Use	USPSTF	Adults		
Vision Screening	BF, USPSTF	Children		
Well Woman Annual Visits	HRSA	Adolescents, Adults		

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Standard 3.B
Medical Services

</div>

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

Measure

3.B.0	PCPCH reports that it routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.	**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 diverse patients.

Specifications for 3.B.0

A practice 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 practice'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 gender- appropriate preventive services[31], including ACIP-recommended immunizations.[32]** If recommended vaccines are not offered onsite, the practice must show evidence of closed-loop referrals to partnering organizations.

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[31] See standard 3.A for examples of age- and gender-appropriate preventive services.
[32] 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.**[33]
   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.

Documentation Required at a Verification Site Visit:
One example of each of the five categories of care listed above demonstrated through clinicians' schedules and/or patients' medical records

Activities that do not meet 3.B.0:
The practice only provides some of the categories of care listed above.

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[33] For information about evidence-based self- management, please visit OHA's Self-Management Programs webpage: Taking Control of Your Health.

Standard 3.C
Behavioral Health Services

This is a must-pass standard. Practices 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 practice's activities (max 30 pts):

3.C.0	PCPCH has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes.	**Must Pass**
3.C.1	PCPCH collaborates and coordinates care or is co-located with specialty mental health, substance use disorders, and developmental providers. PCPCH also provides co-management based on its patient population needs.	**5 points**
3.C.2	PCPCH provides onsite pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	**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, and 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, or 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 for these issues, and provide appropriate treatment, referral, and care coordination for these conditions.

> ✿ **COVID-19 Considerations**
>
> Practices that have made operational changes or experienced a decrease in patient volume because of COVID-19 may use telehealth visits to meet the intent of the measures in this standard. Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

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.

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

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

Specifications for 3.C.0

A practice is meeting measure 3.C.0 if it conducts universal screening of its patients for mental health, substance use disorder, and developmental, behavioral, or social delays (as appropriate). The practice should also identify and document its process for patients who have a positive screen. Additionally, the practice 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.

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating the practice's strategy for screening patients for mental health, substance use, and developmental conditions. Documentation must include the practice's strategy of action when screenings are positive.
2. A list of the standardized tools used to screen for mental health, substance use, and developmental conditions (i.e., SBIRT, PHQ-9, GAD, AUDIT, DAST, CAGE, CRAFFT, M-CHAT-R, Ages and Stages Questionnaires)

Activities that do not meet 3.C.0:
- The practice 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.
- Practice only screens one age group or type of demographic instead of screening all its patients, as appropriate.
- Practice screens patients for a condition but does not have any defined strategy to deal with positive screeners or refer patients to external providers when needed for appropriate treatment that exceeds their capabilities.

Specifications for 3.C.1

A practice is meeting measure 3.C.1 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

> 🎗 **Best Practice**
>
> **Ensuring Health Literacy**
> Given the additional health literacy, linguistic, and cultural barriers in accessing and utilizing behavioral health providers, PCPCHs interested in implementing best practices can work to ensure that behavioral health providers in the referral network, on-site, and in any telemedicine network are culturally and linguistically appropriate, and accessible by individuals with disabilities.

Practices 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 practice to meet measure 3.C.1. This ensures that patients are receiving the types of behavioral health services that are not offered by the practice 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.

Documentation Required at a Verification Site Visit:
1. Evidence of referrals to specialty providers commonly used for entire patient population that address mental health, substance use, developmental, behavioral, or social conditions
2. Shared medical records or documentation in the medical record of regular two-way communication with specialty providers demonstrating active coordination of patient care (e.g. chart notes, phone encounters discussing patients, regular meetings, assessment and diagnosis, treatment plan including medication management and laboratory monitoring, hospitalization, and/or community resource engagement)

Activities that do not meet 3.C.1:
Practice makes referrals to, or is co-located with, external behavioral health providers but does not participate in on-going two-way communication, collaboration, or coordination as a part of the patient's care.

Specifications for 3.C.2

A practice is meeting measure 3.C.2 if it provides on-site medication treatment (pharmacotherapy) to patients with substance use disorders. In addition, the practice must be referring patients that receive pharmacotherapy treatment to recovery supports such as community support groups, peer recovery support services, behavioral health, counseling, or twelve-step group, and following up with patients after referral to ensure completion or determine barriers.

Examples of Pharmacotherapy:[34]

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

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating strategy for providing on-site pharmacotherapy to patients with substance use disorders and referring patients for behavioral counseling or recovery support
2. Evidence of referrals to behavioral counseling or recovery supports
3. Documentation of follow-up with patient after referral

Activities that do not meet 3.C.2:
- For the purposes of 3.C.2, pharmacotherapy does not include Oral Naltrexone or Nicotine replacement therapy (e.g. gum, patches, lozenges, inhalers, etc.).
- A practice 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 practice is meeting measure 3.C.3 if it has an integrated on-site 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, 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 practice's patient population.

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

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

☑ 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 practice utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of its patient population.

☑ For patients that require specialty services or a level of care that is not provided at the practice (e.g. patients with psychiatric needs or developmental disorders), the practice utilizes 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.

⚙ COVID-19 Considerations

Practices that have made operational changes due to COVID-19 and are using telehealth to meet the intent of this measure must still have at least one behavioral health provider that is fully integrated into the practice as specified by these criteria.

Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

Documentation Required at a Verification Site Visit:

1. Evidence that integrated behavioral health providers have appropriate licensure (e.g. job description, chart notes, license, etc.)

2. Documentation of behavioral health provider's weekly schedule with evidence of availability for warm hand offs, same-day appointments, brief assessments, interventions, consultations to practice staff, and inclusion in practice activities such as daily huddles and pre-visit planning

3. Evidence of behavioral health provider documenting interactions with patients including warm hand offs, same-day appointments, brief assessments, and interventions (e.g. chart notes)

4. For behavioral health services not offered by practice's integrated staff, documentation of referrals to, and co-management with, appropriate external behavioral health specialist(s)

Activities that do not meet 3.C.3:

- A behavioral health provider is available onsite, but the practice 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, practice faxes chart notes between the practice 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.

🏅 **Best Practice**

Behavioral Health Provider Staffing

Research on behavioral health provider staffing ratios in primary care practices is still emerging as more practices move toward integrated care. The following resources can help inform your practice's staffing:

Integrated Behavioral Health Alliance of Oregon (2018): Recommended Minimum Standards for PCPCHs Providing Integrated Health Care.

Advancing Integrated Mental Health Solutions (AIMS Center): Caseload Size Guidance for BH Care Managers.

Standard 3.D
Comprehensive Health Assessment & Intervention

This is not a must-pass standard. Practices 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.D.1	PCPCH has a routine assessment to identify health-related social needs in its patient population.	**5 points**
3.D.2	PCPCH tracks referrals to community-based agencies for patients with health-related social needs.	**10 points**
3.D.3	PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs.	**15 points**

Intent of Standard 3.D

Health-related social needs such as housing instability, 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' health- related social needs as part of routine wellness care.

Relevant Definitions

Health-Related Social Needs: 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.

Community-Based Agencies: a public or private organization that is representative of a community or a significant segment of a community and works to meet community needs

Referral tracking: a practice 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.1

A practice is meeting measure 3.D.1 if it has an assessment strategy or assessment tool for health-related social needs that is integrated into the practice workflow for the entire patient population.

Examples:
Examples of health-related social needs assessment tools:
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool (National Association of Community Health Center)
- The EveryONE Project Toolkit (American Academy of Family Physicians)
- Health-Related Social Needs Screening Tool (Accountable Health Communities)
- HealthLeads Screening Toolkit (Health Leads)

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.1:
Providers assess the health-related social needs of their patients on an ad-hoc basis. The assessment is not routine or systematic.

Specifications for 3.D.2

A practice is meeting measure 3.D.2 if it assesses patients for health-related social needs, tracks referrals to community-based agencies, and is able to describe its process for following up with the agencies and/or patients to identify barriers to completing referrals.

Examples:
The practice refers patient 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
3. Documentation of a "closed loop" referral tracking tool or log of referrals (such as an excel spreadsheet), which must include:
   o Referrals to community-based agencies that help meet the needs of patients with health-related social needs.
   o Communication and follow up with the community-based agencies and/or patients, and identification of barriers to completion, if relevant.
   o Final outcome of referrals

Activities that do not meet 3.D.2:
The practice makes a referral to a community-based agency, without any attempt to reach out to the agency and/or patient for follow-up.

Specifications for 3.D.3

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

- ☑ Gathers data on the health-related social needs of its patient population as a whole

- ☑ Analyzes that data to identify target populations or most prevalent health-related social needs

- ☑ Addresses identified population needs through interventions such as collaborative referrals[35] with community-based agencies, self-management resources, or other strategies.

A practice must also meet 3.D.1, and ideally 3.D.2, to effectively meet this measure. Further, the patient population targeted for additional intervention should be specific and identifiable. Interventions should be tailored to effectively accommodate patient needs and practice resource capacity. Ideally, practices will routinely assess the intervention to ensure it meets the needs of their patients.

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[35] Collaborative/cooperative referrals require that a practice have a partnership or cooperative agreement with an organization which involves two-way communication regarding patients' referral status and progress (ex: organization sends monthly list to clinic with patients that received referred services).

Examples:
- A practice uses the PRAPARE tool[36] to assess the health-related social needs among its entire population and tracks closed-loop referrals to local community-based organizations. Upon analyzing the data gathered, it finds food insecurity to be the most prevalent need among its population. In light of this information, the practice creates a food assistance program for its patients.
- A practice screens each of its patients for health-related social needs. It also administers a survey to its entire patient population and analyzes the results to find that many of its Medicaid patients are experiencing housing insecurity. In response, the practice develops a partnership with a local housing assistance organization involving a collaborative referral process: Medicaid patients with a positive screen for housing insecurity are referred to the housing organization and a case worker at this organization regularly updates the practice on the referral status and progress of the patient in receiving housing—which is updated in the patients' chart notes.
- A pediatric practice 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 practice develops a self-management tool for parents and pediatric patients on how to improve the nutrition of their daily meals.

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 practice's overall patient population (e.g., reports, lists, descriptions)
4. Examples of population-based interventions implemented in response to patients' identified needs (e.g., evidence of a partnership with a community-based agency, self-management resources, or other strategies)

Activities that do not meet 3.D.3:
- Practice 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 collected through provider discretion only, on an ad hoc basis, without routine assessment.
- Non-cooperative referrals as the only evidence of intervention.

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[36] National Association of Community Health Centers (2019): PRAPARE Implementation and Action Toolkit.

Standard 3.E
Preventive Service Reminders

This is not a must-pass standard. Practices 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.2	PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders.	**10 points**
3.E.3	PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services.	**15 points**

Intent of Standard 3.E

In addition to providing comprehensive preventive services to patients, PCPCHs that provide proactive outreach to patients, families, and caregivers about preventive services help facilitate timely completion of recommended screenings and interventions.

Specifications for 3.E.2

A practice 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 and has a process for sending them appropriate preventive service reminders.

Examples:
- A practice mails a letter, postcard, or other reminders to relevant patients ages 24-65 years who have not had a pap smear in three years, according to their communication preference, asking them to schedule an appointment for a well-woman exam. For tracking purposes, it is documented in the patient's chart when they are sent a reminder.

- A practice calls every patient with a diabetes diagnosis that does not have a recorded HbA1c in the last six months to ask them to come in for a lab draw. It documents that those calls were made.
- A practice 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.

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating practice's strategy for identifying patients in need of preventive services and sending them appropriate preventive service reminders
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:
- Practice posts signs in the clinic or materials on the website about recommended preventive services.
- Practice sends out a clinic newsletter to patients with a non-personalized list of ages and recommended preventive services.

Specifications for 3.E.3

A practice is meeting measure 3.E.3 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 practice 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.

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating practice's strategy for identifying patients in need of preventive services and sending them appropriate preventive service reminders. Documentation must also include practice's strategy for 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.3:
A practice reminds its patients of upcoming preventive services that are due when patients come in for appointments at the practice, but it does not track its outreach efforts to patients or whether the recommended preventive services have been completed.

> **⚜ Best Practice**
>
> **Health Literacy in Reminders**
>
> To effectively provide preventive services reminders to a practice's diverse patients, a best practice is for the PCPCH 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.

Standard 3.F
Oral Health Services

This is not a must-pass standard. Practices 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 utilizes a screening and/or assessment strategy for oral health needs.	**5 points**
3.F.2	PCPCH utilizes a screening and/or assessment strategy 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 health care. Oral health is an important part of this overall strategy. The intent of this standard is to ensure that PCPCHs routinely provide screenings and/or assessments for oral health needs and help to ensure referral, care coordination, and access to oral health services.[37]

Relevant Definitions

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

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

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

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[37] Society of Teachers of Family Medicine's Smiles for Life: A National Oral Health Curriculum provides resources on integrating oral health and primary care.

Specifications for 3.F.1

A practice 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 practice screens and/or assesses its entire patient population for oral health needs
2. The screening and/or risk assessment tools that the practice utilizes for both adult and pediatric patients
3. Evidence of how screening and/or risk assessment results are documented (i.e., snapshots of patient charts of both adult and pediatric patients, spreadsheets, or EHR reports)

Activities that do not meet 3.F.1:
- A family practice only has an oral health screening protocol for children and pregnant patients but not for all adults. The practice does not screen the entire patient population served at practice.
- A screening is used for the pediatric population and a risk assessment is used for the adults. However, the practice does not have a policy or procedure describing the screening strategy process.

Specifications for 3.F.2

A practice 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. The strategy must include how the practice identifies its priority patient populations or patients who are at high risk for oral health care needs, along with the interventions provided. 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 disorder, and patients with specific medical

conditions such as heart disease, diabetes, or being immunocompromised.[38] 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 practice 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 practice assess 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 practice 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 practice 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 practice screens and/or assesses its entire patient population for oral health needs. Documentation must include criteria used to identify the oral health priority populations at the practice.
2. The screening and/or risk assessment tools that the practice utilizes for both adult and pediatric patients
3. Evidence of how screening and/or risk assessment results are documented (i.e., snapshots of patient charts of both adult and pediatric patients, spreadsheets, or EHR reports)
4. A log or tracking method for common oral health interventions with documented follow-up. The tracking method does not have to be done electronically via an EHR system.

Activities that do not meet 3.F.2:
- A practice does not screen and/or assess its entire patient population for oral health needs.
- A practice has not identified which patient populations are prioritized for oral health interventions.
- A practice 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 practice excludes certain segments of its patient population from receiving oral health services based on insurance coverage.

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[38] Resource: Oregon Oral Health Coalition's Oral Health and Chronic Disease Integration Guide & Resources.

Specifications for 3.F.3

A practice 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 practice site and accessible to the entire patient population.

Examples of oral health services:
- Fluoride access
- Teeth Cleaning
- Caries treatment
- Preventive exam
- Dental Emergency Care
- Before First Tooth guidance
- Early Childhood Caries Prevention Services/ First Tooth[39]
- Introduction/establishment to oral health home
- Collaborative practice agreements between oral health and primary care teams

★ **Transformation in Practice**

A practice has integrated oral health services, which are available for 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 practice 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 practice screens and/or assesses its entire patient population for oral health needs. Documentation must include criteria used to identify the oral health priority populations at the practice.
2. The screening and/or risk assessment tools that the practice utilizes for both adult and pediatric patients
3. Evidence of how screening and/or risk assessment results are documented (i.e., snapshots of charts of both adult and pediatric patients, spreadsheets, or EHR reports)
4. A log or tracking method for common oral health interventions with documented follow-up. The tracking method does not have to be done electronically via an EHR.
5. Evidence of oral health services provided onsite at the practice (e.g. chart notes of both adult and pediatric patients)

Activities that do not meet 3.F.3:
- A practice sponsors a mobile van within the community but the services it offers are only available to those with specific health insurance coverage.
- The dental provider is not on site 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.

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[39] First Tooth Integration Guide provided by the Oregon Oral Health Coalition.

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Standard 4.A
Personal Clinician Assigned

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This is a must-pass standard. Practices 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.	**Must Pass**
4.A.3	PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team.	**15 points**

Intent of Standard 4.A

Interpersonal continuity of care is a core component of primary care and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that PCPCHs can monitor and measure whether patients are assigned to a personal clinician or health care team. PCPCHs should seek to promote patients' relationships with their personal clinician and health care team.

Not all practices have implemented a team-based care model, and among those that have, the team composition may look different from practice to practice. For those operating in a team-based care model, the focus should be on how the team functions to provide continuity of care for their patients, including shared communication and responsibility for a defined set of the practice's population. Also, patients should know which team they belong to, and understand that they are known by other members of their health care team.

Relevant Definitions

Active Patients: A subset of the total number of patients that receive primary care at the practice. Active patients are patients who have had at least one office visit with any primary care clinician or team member at the practice during a set time period prior to PCPCH application submission. This time period varies by practice 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: For the purposes of this standard, a "team" includes a minimum of two primary care providers (MD, DO, ND, NP, PA) who collectively take responsibility for a set of patients. Teams

may also incorporate other members such as a nurse care manager, medical assistant, front desk staff, behavioral health provider, or community health worker. If a team is used for continuity calculations instead of individual clinician, then patients must be routinely informed of which team they belong to and what the team-based care model means for their care.

Specifications for 4.A.0

A practice is meeting measure 4.A.0 if it has a standard method for assigning its patients to a personal clinician or team and reports the percent of its active patients assigned to a personal clinician or team using the formula and instructions outlined below. Practices report this percentage to the OHA through the PCPCH Online Application. Practices 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.

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

Denominator: All patients meeting the definition of active patient.

Sample Size – Practices have two options for compiling data:
- Generate a report from an electronic system demonstrating the percentage of all active patients at the practice with an assigned personal clinician or team;
- Conduct a random chart audit of at least 30 active patient records to determine if a primary clinician or team is assigned (if the practice does not have an electronic system for compiling the data).

Sampling Frequency – Practices are expected to assess the percentage of patients with an assigned personal clinician at least annually.

Examples:
Strategies to document assignment of a personal clinician:
- Using a standard field in an electronic medical record or practice management software.
- If using paper charts, clear identification of the personal clinician or team on a patient's chart.
- Whenever possible, patients' assignment to a personal clinician or team should be based on patient choice.

Sample calculation for 4.A.0: In the last 12 months a practice has 3,428 patients that have had at least one office visit at the practice. 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 4.A.0 = 87.14%

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating how patients are assigned to a personal clinician or team
2. Data used to calculate the percentage of active patients assigned to a personal clinician or team

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.

Specifications for 4.A.3

A practice is meeting measure 4.A.3 if 90% or more of its active patients are currently assigned to a personal clinician or team. Practices must report this percentage to the OHA on their PCPCH recognition application using the formula and instructions outlined below:

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

Denominator: All patients meeting the definition of active patient.

Sample Size – Practices have two options for compiling data:
- Generate a report from an electronic system demonstrating the percentage of all active patients at the practice with an assigned personal clinician or team;
- Conduct a random chart audit of at least 30 active patient records to determine if a primary clinician or team is assigned (if the practice does not have an electronic system for compiling the data).

Sampling Frequency – Practices are expected to assess the percentage of patients with an assigned personal clinician at least annually.

> **Best Practice**
>
> **Staff and Patient Diversity**
>
> Whenever possible, patients' assignment to a personal clinician or team should be based on patient choice and optimize the provision of culturally and linguistically appropriate services (e.g. assigning a personal clinician who speaks the primary language of the patient or has a trained health care interpreter as part of the health care team). Having a workforce that reflects the diversity of one's patients (or customers in any business) results in improved trust, loyalty, and satisfaction.[40] While recognizing the challenges in maintaining any practice's staffing, larger practices can include workforce diversity strategies in the recruitment, hiring, training, and promotion of practice staff to optimize patient experience and satisfaction.

[40] Loucel, C. (2012). In Health Care, Diversity Matters. University of California, San Francisco.

Sample calculation for 4.A.3: In the last 12 months a practice has 3,428 patients that have had at least one office visit at the practice. Out of these 3,428 patients, 3,256 patients are assigned to a personal clinician or team.

4.A. Numerator = 3,256

4.A. Denominator = 3,428

% for 4.A = 94.98%

In this example, the practice met the 90% benchmark for 4.A.3

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating how patients are assigned to a personal clinician or team
2. Data used to calculate the percentage of active patients assigned to a personal clinician or team

Activities that do not meet 4.A.3:

The practice assigns active patients to a personal clinician or team but does not meet the 90% benchmark.

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Standard 4.B
Personal Clinician Continuity

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

Measures

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

4.B.0	PCPCH reports the percent of patient visits with assigned clinician or team.	**Must Pass**
4.B.2	PCPCH tracks and improves the percent of patient visits with assigned clinician or team.	**10 points**
4.B.3	PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.	**15 points**

Intent of Standard 4.B

Continuity of care is a core component of primary care and is associated with improved health care outcomes and patient experience. The intent of this standard is to ensure that PCPCHs can measure and improve patients' continuity with an assigned personal clinician or health care team over time. PCPCHs should seek to promote patients' relationships with their personal clinician and/or health care team.

Not all practices have implemented a team-based care model, and among those that have, the team composition may look different from practice to practice. For those operating in a team-based care model, the focus should be on how teams function to provide continuity of care for their patients, including shared communication and responsibility for a defined set of the practice's population. Also, patients should know which team they belong to, and understand that they are known by other members of their health care team.

Relevant Definitions

Active Patients: All patients with at least one office visit with any primary care clinician or team member at the practice during the past 12 months prior to PCPCH application submission. "Active patients" are a subset of the total number of patients that receive primary care at the practice.

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: For the purposes of this standard, a "team" typically includes 2-4 providers (MD, DO, ND, NP, PA) who collectively take responsibility for a set of patients. Teams may also incorporate other members such as a nurse care manager, medical assistant, front desk staff, behavioral health provider, or community health worker. If a team is used for continuity calculations instead of individual clinician, then patients must be routinely notified/informed of which team they belong to and what the team-based care model means for their care.

Personal Clinician or Team Assignment: Practices that have implemented care teams can report continuity data based on patient visits with their health care team. All other practices must report continuity data based on individual clinician assignment. Practices must demonstrate a standard method of documenting every patients' assignment to a personal clinician or team.

Specifications for 4.B.0

A practice is meeting measure 4.B.0 if it reports the percent of patient visits/appointments in which the patient saw their assigned clinician or team. Practices must use the formula and instructions below to calculate this percentage and report it to the OHA on their PCPCH recognition application.

Practices are required to report a numerator and denominator at the time of application submission for this standard. Practices that have implemented the team-based model of care can report continuity data based on patient visits with their assigned health care team. All other practices must report continuity data based on individual clinician assignment. If a team is used for continuity calculations instead of individual clinician, then patients must be routinely notified/informed of which team they are assigned.

Numerator: Number of patient visits/appointments during the last 12 months when patients saw their assigned clinician or team.

Denominator: Total number of patient visits/appointments during the last 12 months for patients meeting the definition of "active patient."

Note: If the practice does not include RN or other care team member visits in the numerator, exclude these visits from the denominator.

There are some circumstances that may warrant calculating continuity numbers differently, such as the use of locums or clinicians on family leave. If you have questions about how to calculate your practice's continuity data, please contact the program office at PCPCH@oha.oregon.gov.

Sample Size – Practices have one of two options for compiling data:
- Generate a report from an electronic system demonstrating the total number of patient visits/appointments at the practice with an assigned personal clinician or team during the 12 months prior to PCPCH application submission OR;

- Conduct a random chart audit of at least 30 active patient records to determine the number of patient visits/appointments with assigned clinician or team (if a practice does not have an electronic system for compiling the data).

Note: the same data collection method for 4.B should be used for 4.A.

Sampling Frequency – Practices are expected to assess continuity of visits with the patients' clinician/health care team at least annually.

Documentation Required at a Verification Site Visit:
1. Data used to calculate continuity, which clearly indicates the names of the assigned providers or care teams
2. *If practice is using team-based care model:* Documentation demonstrating that patients are routinely informed of which team they belong to and what the team-based care model means for their care (e.g. patient welcome packet, website, poster in the lobby)

Activities that do not meet 4.B.0:
The practice employs a care team model, but team members are not assigned, delineated, or documented in a systematic manner.

Specifications for 4.B.2

A practice is meeting measure 4.B.2 if it improves on the percent of patient visits/appointments in which the patient saw their assigned clinician or team. Practices must use the formula and instructions below to calculate their improvement and demonstrate ≥ 10 percentage point improvement in reported scores over a period of one year, or ≥ 5 percentage point improvement over 6 months.

Example:
In the last 12 months, a practice showed a 10% increase from the previous year in the number of visits/appointments in which its patients saw their assigned personal clinician or team.

2019 = 7,543 visits with the assigned clinician out of 11,423 **7543/11432** = 66%

2020 = 8944 visits with the assigned clinician out of 11,665 **8944/11665** = 76%

Documentation Required at a Verification Site Visit:
1. Summary of the data used to calculate continuity, which clearly indicates the names of the assigned providers or care teams
2. Data demonstrating ≥ 10 percentage point improvement in reported scores over a period of one year, or ≥ 5 percentage point improvement over 6 months
3. *If practice is using team-based care model:* Documentation demonstrating that patients are routinely informed of which team they belong to and what the team-based care model means for their care (e.g. patient welcome packet, website, poster in the lobby, etc.)

Activities that do not meet 4.B.2:
Practice is unable to demonstrate the required improvement of ≥ 10 percentage point improvement in reported scores over a period of one year, or ≥ 5 percentage point improvement over 6 months.

Specifications for 4.B.3

A practice is meeting measure 4.B.3 if patients saw their assigned clinician or team in 80% or more of patient visits/appointments during the last 12 months.

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

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

In this example, the practice met the 80% benchmark for 4.B.3

Documentation Required at a Verification Site Visit:
1. Data used to calculate 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
2. *If practice is using team-based care model:* Documentation demonstrating that patients are routinely informed of which team they belong to and what the team-based care model means for their care (e.g. patient welcome packet, website, poster in lobby, etc.)

Activities that do not meet 4.B.3:
- A practice 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 practice 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.

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Standard 4.C
Organization of Clinical Information

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

Measure

4.C.0	PCPCH uses an electronic health record (EHR) technology that is certified by the Centers for Medicare and Medicaid Services and includes the following elements: problem list, medication list, allergies, basic demographic information, primary language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.	**Must Pass**

Intent of Standard 4.C

Implementation and use of an electronic health record is an essential tool for achieving many advanced primary care home functions such as improved population tracking, care coordination, improved communication, and patient safety. PCPCHs must maintain comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as patients move throughout the health care system. Maintaining a health record with up-to-date information is an essential prerequisite to managing safe transitions of care between health care providers.

Relevant Definitions

Certified Electronic Health Record: an electronic health record (EHR) that is certified by the Centers for Medicare and Medicaid Services (CMS).[41] All PCPCHs are required to use a certified EHR

Specifications for 4.C.0

A practice is meeting measure 4.C.0 if it uses a CMS-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

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[41] The HealthIT.gov "Certified Health IT Product List" contains an updated list of all EHRs that are certified by CMS: https://chpl.healthit.gov/#/search (note: this link cannot be opened using Microsoft Internet Explorer; must use another browser).

☑ 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 practice should have a clear process for ensuring that they are regularly reviewed and updated by staff.

Example:
A practice uses a CMS-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 practice also asks all patients what name and gender pronoun they prefer and documents this information in the EHR .

Documentation Required at a Verification Site Visit:
Proof of EHR Certification[42]

Activities that do not meet 4.C.0:
- Documenting the above data elements in a paper chart.
- Using a non-certified EHR.

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[42] Practices can search for their specific EHR version within HealthIT.gov's "Certified Health IT Product List" at https://chpl.healthit.gov/#/search and print off the required certification (note: this link cannot be opened using Microsoft Internet Explorer; must use another browser).

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Standard 4.D
Clinical Information Exchange

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This is not a must-pass standard. Practices 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 (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

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.

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

Specifications for 4.D.2

A practice 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,[43] problem lists, medication lists, allergies, laboratory and imaging, other diagnostic test results, and recent practice notes. This can be done by logging in daily to another practice's or hospital's system or portal in order to send or receive electronic information.

Additionally, the practice 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 or a similar bi-directional electronic communication
- ☐ One other electronic communication method such as eReferrals, EHR secure messaging, or EHR diagnostic imaging and/or lab result integration

Examples:
- Every morning the practice's care coordinator logs into the hospital system to see if there have been any new hospital admissions or discharges. They transmit the hospital records into their EHR system for follow-up with the patient. The practice is also utilizing hospital notifications like the Collective Medical platform and uses secure messaging through its EHR to communicate with external provider partners.

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating daily log-in to another system for information exchange that includes what system is being used and what type of information is being exchanged
2. Evidence demonstrating that the practice 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:
- The practice does not have a protocol for daily log-in for data exchange. The practice only exchanges data randomly and at will, when necessary.
- The practice has secure faxing or e-faxing of patient records with other providers or care entities.
  The practice is not meeting two of the three categories of electronic information exchange methods listed above.

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[43] For example, it would be important for the clinic to share the language and communications 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 practice 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 practice notes. The practice must also be able to receive important information in patient records that are available electronically from other care providers. These records are sent bi-directionally in real-time and do not require a separate log-in to another portal or system to send or receive documents.

Examples:
- The practice participates in a HIE via their EHR vendor (e.g., Carequality, Epic Care Everywhere) or a regional/community-based HIE integrated into their EHR interface (e.g., Reliance eHealth Collaborative).
- The practice has an arrangement with its usual hospital, emergency, and specialty care providers to have real-time electronic access to the practice's EHR or use of a shared EHR (e.g., EPIC).
- The practice uses Direct Secure Messaging or other HIE solutions to ensure providers have at least one option for information exchange with other unaffiliated providers, care coordinators, and patients, regardless of the type of electronic health record system in use. The practice 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:
1. The name(s) of the software/system used to share real-time patient information electronically with hospitals, emergency rooms, and specialty providers
2. Examples of exchanging data bi-directionally in real-time with hospitals, ERs, and specialty providers in real time

Activities that do not meet 4.D.3:
- The practice has a one-directional portal to see lab or imaging results in the local hospital EHR
- The practice participates in an immunization registry
- The practice electronically reports laboratory tests to their local public health department
- The practice has secure faxing or e-faxing of patient records with other providers or care entities
- Referral tracking and management systems used only

Standard 4.E
Specialized Care Setting Transitions

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

Measure

4.E.0	PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	**Must Pass**

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 usual providers of hospital care.

Relevant Definitions

Usual Hospital Providers: the hospital(s) or hospitalist group(s) that most frequently care for the primary care home's patient population when admitted to a hospital or visiting the emergency room

Specifications for 4.E.0

A practice is meeting measure 4.E.0 if it has a written agreement in place with the usual hospital providers that care for its patient population and can describe the how it meets the expectations of the agreement. This hospital agreement should include, among other protocols:

- ☑ The practice's process for requesting hospital admission for patients
- ☑ Expectations for hospital communication with the practice at the time of patients' hospital admission
- ☑ The practice's process for sharing patient medical records at the time of hospital admission
- ☑ How the hospital communicates patient discharge summary with practice at the time of hospital discharge
- ☑ Practice's process and performance expectations for scheduling after-discharge follow-up appointments.

Examples:
- In order to ensure the best continuity of care for its patients, a practice has written agreements with all the hospitals in the area in which its patients receive care. This ensures that the practice 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 practice.
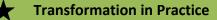
- A practice has had a long-standing agreement in place with a local hospital reflecting the longevity of their collaborative relationship. The practice routinely reviews the hospital agreement to ensure that the processes outlined in the hospital agreement remain relevant for its patient population, and makes changes if needed.
- A practice is part of a system which includes a hospital and has a written agreement 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.

Documentation Required at a Verification Site Visit:
1. A copy of the written agreement, including evidence that the usual hospital providers agree to the principles, policies, and procedures in the agreement.
2. Examples of hospital admission requests and discharge notifications, including date and time. In practices that do not directly admit patients to the hospital, evidence of communication with ED staff when the patient is sent to be evaluated for possible admission.

Required documentation for providers that routinely provide hospital services to their patients:
1. A formal workflow or protocol around hospital coverage

★ **Transformation in Practice**

Care Setting Transitions

A practice receives an electronic notification when patients are discharged from the hospital. The practice has a transition of care workflow that includes outreach to the patient to coordinate and schedule follow up appointments with their primary care provider, pharmacist, and behavioral health consultant. By coordinating a range of supportive services for patients after a hospital discharge, the practice is ensuring that its patients are receiving the proper care they need during this transition of care.

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Standard 4.F
Planning for Continuity

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This is not a must-pass standard. Practices 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

4.F.1	PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	**5 Points**

Intent of Standard 4.F

This standard is a functional step inherent in completing several other standards. It is important for a practice to plan 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.1

A practice is meeting measure 4.F.1 if is able to describe how 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 of how the practice 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.

Documentation Required at a Verification Site Visit:
Policy, procedure, or workflow demonstrating strategy for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available, as outlined above

Activities that do not meet 4.F.1:
- 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 practice has a written policy, but staff are unable to describe how coverage is provided to patients while their team members are unavailable

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Standard 4.G
Medication Reconciliation & Management

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This is not a must-pass standard. Practices 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.G.2	PCPCH has a process for medication reconciliation for patients with complex or high-risk medication concerns.	**10 points**
4.G.3	PCPCH provides Medication Management for patients with complex or high-risk medication concerns.	**15 points**

Intent of Standard 4.G

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

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[44]

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 (e.g., diabetes, chronic pain, Attention Deficit Hyperactivity Disorder, or asthma)

Comprehensive Medication Management: the standard of care that ensures each patient's medications (i.e., prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for

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[44] A toolkit on medication reconciliation is available from Northwestern Memorial Hospital and the Island Peer Review Organization: Agency for Healthcare Research Quality. (2012). [Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation](#).

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

Specifications for 4.G.2

A practice is meeting measure 4.G.2 if it ensures that patients with complex or high-risk medication concerns receive medication reconciliation. This goes beyond a basic medication check at every appointment and includes the entire medication reconciliation process as described in the definition provided.

Staff must know who is responsible for medication reconciliation and the steps they take to complete medication reconciliation. A qualified healthcare professional must discuss medication changes with patients if they are identified during medication reconciliation.

Examples:

- The practice has determined that patients with 5 or more prescriptions will receive a medication reconciliation at every appointment. The medical assistant has been trained by the provider on how to administer a complete medication reconciliation with the patient. If there are any changes in the patient's medications, the provider is notified and has a conversation with the patient about changes to their prescriptions.
- 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, and this is discussed with the patient's provider.

🎗 **Best Practice**

Health Literacy & 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 interested in implementing best practices 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.

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating how the practice completes medication reconciliation for patients with complex or high-risk medication concerns
2. Chart note examples of medication reconciliation for patients that are complex or have high-risk medication concerns

Activities that do not meet 4.G.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 (see definition on page 101).
- Patient/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 list are not discussed with a qualified healthcare provider.

Specifications for 4.G.3

A practice is meeting measure 4.G.3 if it has a clinical pharmacist who works with the care team and performs the following types of functions for patients that the practice has identified as having complex or high-risk medication concerns. These services should be available for enough hours each week to adequately address the needs of the practice's patient population:

☑ 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.

☑ Plans follow-up evaluation and medication monitoring that includes assessment of patients' progress toward treatment goals.

> ⚙ **COVID-19 Considerations**
>
> Practices that have made operational changes or experienced a decrease in patient volume because of COVID-19 may use telehealth visits to meet the intent of this measure, as long as the pharmacist(s) are still integrated into the PCPCH according to these criteria.
>
> Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

Example:

A clinical 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. They are in the practice to see patients for appointments and are available for warm hand-offs as patients with complex or high-risk medication concerns arise. Additionally, they coordinate with other care team members and participate in staff meetings and quality improvement activities or other integration projects. In other words, they are fully integrated as a member of the patient's care team.

Documentation Required at a Verification Site Visit:
1. Job description or written collaborative practice agreement for clinical pharmacist
2. Schedule template or other document showing the hours/days the clinical pharmacist is in the practice
3. Chart note examples of comprehensive medication management plans. These must include the following elements and be developed in partnership with patients:
    o Medication reconciliation during office visits and transitions of care
    o Clear communication of desired clinical outcome(s) for each medication in use
    o Monitoring of progress toward desired clinical outcome(s)
    o Review and discussion of therapeutic goals with the patient and care team
    o Planned follow-up intervals with the patient

Activities that do not meet 4.G.3:
- Care team member(s) perform medication reconciliation at an office visit, but does not engage in proactive and coordinated medication management and does not involve an integrated clinical pharmacist.
- A practice utilizes a pharmacist who functions operationally in isolation from other members of the care team and lacks opportunities to collaborate in real-time with the care team and patients.
- A system-wide clinical pharmacist is only available for in-person or phone consultations with the provider and does not meet directly with patients.

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Standard 5.A
Population Data Management

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This is not a must-pass standard. Practices 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 practice's activities (max 15 pts):

5.A.1	PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its entire patient population, including the identification of sub-populations.	**5 points**
5.A.2	PCPCH demonstrates the ability to stratify its entire patient population according to health risk such as special health care needs or health behavior.	**10 points**

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 basic information about its patient population. Practices should demonstrate an ability to use this data to proactively manage a population of patients with a specific disease or health care need.

Definitions

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.[45] A practice 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 practice is meeting measure 5.A.1 if it generates, analyzes, and uses up-to-date data on its entire patient population for patient management or tracking of a particular disease-state or health care need. Patient management implies that a practice actively monitors the health care

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[45] Description from the National Association of Community Health center's Action Guide (2019): Population Health Management-Risk Stratification. Additional tools include the Risk-Stratified Care Management and Coordination matrix provided by the American Academy of Family Physicians.

needs of a sub-population of its patients and seeks to identify and correct "gaps" where indicated care has not been given.

Examples:
- The practice queries its practice management system or EHR to identify the practice's most commonly seen diagnoses or produce aggregated demographic information about its patient population (e.g., the most common chronic conditions in the practice's population, percentage of patients in certain age groups or by gender, race, ethnicity, and/or primary language).
- The practice maintains an active searchable registry of patients with a specific condition (e.g., diabetes, pregnancy). Registries can sometimes be integrated in the EHR, but practices can also use a simple tracking system, such as Microsoft Excel.[46]
- The practice uses a list of patients to generate patient reminder outreach for indicated care (e.g., mammograms, well-child appointments, immunizations).
- The practice 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).
- The practice keeps a registry of pregnant patients and follows up with those who miss appointments for prenatal care.
- The practice generates an inclusive list of patients in the practice 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 practice that are used to track and proactively manage patients with specific conditions or health care needs (e.g., mammograms, well-child appointments, HbA1c, lists of patients being follow up after emergency room discharge)

Activities that do not meet 5.A.1:
- The practice has the capability to generate a list of patients in the practice 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 practice 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 practice's entire patient population.

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[46] Oritz, D. (2006). Using a Simple Patient Registry to Improve Your Chronic Disease Care. *Family Practice Management*, 13(4), 47-52. Bagley, B., & Mitchell, J. (2011). Registries Made Simple. *Family Practice Management*, 18(3), 11-14.

Specifications for 5.A.2

A practice is meeting measure 5.A.2 if it implements and uses an evidence-based risk stratification process[47] on its entire 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 practice. The practice 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 practice implements a risk stratification strategy for its patient population based upon disease states, psychosocial risks, and/or cultural/linguistic-based risks to most effectively target interventions, care coordination, and care planning resources for their patients.
- The practice utilizes an evidence-based tool or process to stratify their patient population based upon risk and can provide lists of patients and their risk assignment.
- The practice collaborates with an independent physician association (IPA) or other organization to assign risk stratification to its complete patient population and can produce lists of patients and their risk assignments. These lists are not be limited to subset of patients at the practice.

> **🎖 Best Practice**
>
> **Racial Biases in Data Collection**
> Research has shown a racial bias in popular risk stratification algorithms,[48] especially when using health costs as a proxy for health needs. While there are no perfect or quick fix for systemic inequities or large-scale algorithm development and implementation, PCPCHs interested in implementing best practices 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. Policy, procedure, or workflow that demonstrates how the risk stratification process is implemented by the practice, including the criteria used to determine each level of risk
2. De-identified lists, registries, or trackers demonstrating how the practice is tracking patients who meet the criteria for selected risk stratification categories

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[47] Additional resources on risk stratification provided by the American Academy of Family Physicians: [Risk Stratified Care Management and Coordination](#) and [Identifying High-risk, High-cost Patients is Step One to Improving Practice Efficiency.](#)

[48] Ledford, H. (2019). [Millions of Black people affected by racial bias in health-care algorithms](#). *Nature*. 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 practice has performed a risk stratification process, but only for a subset of its patient population.
- The practice has performed a risk stratification process but does not periodically review and adjust risk scores accordingly.
- The practice has an automated risk stratification process built into their EHR and patients are automatically assigned a risk score, but practice staff are not aware of what the score means, or how it is utilized for patient care within the practice.

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Standard 5.C
Complex Care Coordination

</div>

This is not a must-pass standard. Practices 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 practice's activities (max 30 pts):

5.C.1	PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care.	**5 points**
5.C.2	PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs.	**10 points**
5.C.3	PCPCH collaborates with diverse patients, families, or caregivers to develop individualized 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 who they can contact at the practice to help coordinate their care. 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: Care coordination is 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. (Agency for Health Research and Quality 2014)

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.

Specifications for 5.C.1

A practice is meeting measure 5.C.1 if it has a person(s) 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.

To meet this measure, a practice must illustrate clear assignment of care coordination responsibilities to practice staff and clear communication to patients, families, and caregivers about how to obtain these services. Care coordination functions within the practice 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 whom to contact 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.

Documentation Required at a Verification Site Visit:
Policy, procedure, or workflow that demonstrates which staff members perform care coordination roles and what care coordination duties they are responsible for (e.g., staff member X maintains a log tracking test results)

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.

> **Best Practice**
>
> **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

Specifications for 5.C.2

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

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 practice 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 practice uses to identify diverse patients with "complex health care needs" that would benefit from care coordination
2. Evidence that practice is tracking which patients are receiving care coordination for those complex health care needs
3. Written demonstration of the activities performed by practice staff to assist with care coordination for diverse individuals with complex health care needs

Activities that do not meet 5.C.2:
Identification of complex care coordination on a case-by-case basis, based on provider discretion or an unofficial/undocumented process.

Specifications for 5.C.3

A practice 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.[49] The care plans should include, at a minimum:

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[49] Additional resources and care plan templates can be found on the PCPCH Resources and Technical Assistance webpage, and the Agency for Healthcare Research and Quality Develop a Shared Care Plan webpage.

☑ 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 112-113 (primary and supportive services) that the practice 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 practice, 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 practice 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)[50] 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 practice 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 practice staff should be aware of this workflow and be able to identify the roles at the practice 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 practice
- Behavioral health or substance use disorder treatment(s)
- Barriers to care and potential solutions
- Psychosocial concerns and coordination of health-related social needs
- Coordination with sub-specialists

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

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[51]
- Home care/nursing services
- Developmentally Disabled (DD) Waiver

Example:
A pediatric practice 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 practice. 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 practice, 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
- Copy-pasting 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.
- Less than 3 of the primary or supportive elements described above are included in the patient's care plan.
- Practice develops a care plan for each patient instead of collaborating with the patient and/or family or caregivers to develop personal goals.

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

Standard 5.D
Test & Result Tracking

This is not a must-pass standard. Practices 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, families, or caregivers as well as to ordering clinicians.	5 points

Intent of Standard 5.D

Test tracking is an important aspect of care coordination. This standard is intended to ensure that PCPCHs 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 practice 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 prior to order expiration. 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 practice uses a log to track tests that are ordered (e.g. laboratory tests, imaging). The log clearly identifies whether test results have been received by the practice and whether the patient and ordering clinician have been informed of the test results. The practice explains the results to patients, families, and/or caregivers in their preferred form of communication (e.g. via phone, portal messages or letters) and documents this in the tracking system. To ensure

completion of ordered tests, the practice also has a workflow for designated staff to follow up on tests that have not been completed by the patient before the order expiration.

Documentation Required at a Verification Site Visit:
Policy, procedure, or workflow demonstrating:
- How the practice 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 practice follows up with patients who have had tests ordered but have not completed them

Activities that do not meet 5.D.1:
- The practice 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.
- The practice tracks only received test results; it cannot determine if a test has been ordered but not performed.
- The practice conveys results to patients, families, or caregivers without explaining what they mean, the implications of the results, and/or how this may or may not affect their treatment.

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Standard 5.E
Referral & Specialty Care Coordination

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This is not a must-pass standard. Practices 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 practice'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 demonstrates active involvement and coordination of care when its patients receive care in specialized settings (e.g., hospital, SNF, long term care facility).	**10 points**
5.E.3	PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social services, foster care (either adult or child), public health, traditional health workers, school-based health centers, behavioral health providers and organizations, and pharmacy services.	**15 points**

Intent of Standard 5.E

PCPCHs are a critical partner in the "health care neighborhood." Understanding and coordinating patient care outside of the practice is an important role of a PCPCH. Practices 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. These measures are intended to ensure that PCPCHs take responsibility for coordinating care offered outside of their walls.

Relevant Definitions

Referrals: A practice engages in referrals when it directs a patient to a specialist, service, or organization that is external to the clinic.

Referral follow-up: A practice 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 practice 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 appointment/ service)

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

Specifications for 5.E.1

A practice is meeting measure 5.E.1 if it is able to describe its system for tracking 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.

Examples:
- Practice 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.
- Practice 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 practice'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 practice only tracks a subset of referrals to consulting specialty providers.
- The practice 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 practice 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, 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 practice 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 practice 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 practice has regular, direct communication with patients, families, and/or caregivers for patients who are receiving care in SNF. This helps the practice facilitate care coordination and schedule follow-up care with them.
- A clinician at a practice provides regular in-house visits or serves as medical director for a long-term care facility where the majority of the patients in the practice receive care.
- THWs at a practice 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.

Documentation Required at a Verification Site Visit:
1. Policy, procedure, or workflow demonstrating how the practice identifies patients in a specialized care setting
2. Examples from the medical record of care coordination for patients in specialized settings. The examples must demonstrate two-way communication

Activities that do not meet 5.E.2:
- The practice only participates in one-way communication with a specialized setting.
- The practice 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. is not actively calling 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 practice is meeting measure 5.E.3 if it is able to describe how it identifies patients that might benefit from external community service providers, coordinates with these entities to provide care, and tracks referrals in order to meet the health and social needs of diverse patients. Referral tracking must include follow-up with either the patients or the community service providers.

Examples of community entities include dental clinics, educational programs, social service agencies, transportation services, housing resources, food resources, foster (resource) care, public health agencies, school-based health care providers, behavioral health providers/organizations, traditional health workers, and pharmacy services.

Examples:
- A practice demonstrates collaborative management of patient health with diverse community organizations, including two-way communication which is documented in individual patient charts. The status of the patients' referral is also noted and tracked in the EHR.
- A practice maintains a care of coordination spreadsheet outside of the EHR to track transportation referrals with local transport providers, and documents whether patients/families were able to remove their barrier to coming in for medical appointments.
- THWs support patients, families and/or caregivers in navigating and making connections to external social and community services (e.g., public health, school systems, foster (resource) care, housing, employment, etc.). THWs continue to maintain two-way communication with the external service and coordinate any follow-up as appropriate.

Documentation Required at a Verification Site Visit:
1. A log or tool that tracks referrals to community service providers, with documented follow-up with community service provider and/or patient or caregiver
2. Examples of two-way communication with community agencies that demonstrates care coordination (e.g. chart notes, phone notes, referral notes)

Activities that do not meet 5.E.3:
- The practice does not regularly track community referrals to external community service providers.
- The practice tracks referrals to external community service providers but does not engage in two-way communication to confirm whether patients were able to access referred services.
- The practice tracks referrals to external community service providers but does not follow up with patients or the community organizations.

🏅 **Best Practice**

Importance of Referral Tracking in the Health Care Neighborhood

PCPCHs interested in implementing best practices should strive to help coordinate and track all care their patients receive outside of their primary care home. The "health care neighborhood" is not necessarily a geographic community, but a set of relationships between patients, families, and caregivers, and based on everyone's health care needs. Practices should strive to track referrals to culturally and linguistically appropriate specialty mental health services and diverse community-based resources, such as housing and food assistance.

For example, a patient with diabetes may benefit from nutrition services from a local community organization that provides home-delivered meals and from a local YMCA that promotes exercise and other physical activities. While some of these community services may initially seem to be outside of the responsibility of a medical provider, coordination by the PCPCH may result in more effective referrals and follow-up by patients than clinical treatment plans. It is important that referrals for diverse populations to community services reflect patients' primary language or cultural practices. For example, a tobacco cessation program conducted in Spanish is for more effective for Spanish-speaking patients.

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Standard 5.F
End of Life Planning

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

Measures

Progressive – Select the level that best describes your practice (max 5 pts):

5.F.0	PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	**Must Pass**
5.F.1	PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries unless patients opt out.	**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 practice. It is also important that practices 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.

Relevant Definitions

POLST: Physician Orders for Life-Sustaining Treatment

Specifications for 5.F.0

A practice is meeting measure 5.F.0 if it is able to describe how 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:
- The practice maintains a list of usual referral providers for hospice or palliative care (including admission criteria for these providers) and refers patients when appropriate.

- The PCP counsels families about hospice or palliative care options in their region.
- The practice uses hospice or palliative care plans that are developed or approved by its clinicians.

Documentation Required at a Verification Site Visit:
Examples of patient referrals from the medical record or (in practices where no referrals have been needed) a policy, protocol, or workflow for offering this service should the need arise

Activities that do not meet 5.F.0
The practice has a list of hospice or palliative providers or facilities but cannot provide examples of patient referrals or a policy or protocol for offering these services.

Specifications for 5.F.1

A practice is meeting measure 5.F.1 if it proactively engages patients, families, and/or caregivers in 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.[52]

Examples:
- A practice completes end-of-life planning documents with patients such as advanced directives, living wills, or POLST forms that are contained within patient records.
- 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.

Documentation Required at a Verification Site Visit:
Chart note examples showing proactive end of life planning and counseling

Activities that do not meet 5.F.1:
The practice provides evidence of POLST forms in patient charts, but the forms are not routinely filled out with the help of the providers and the practice cannot provide any other example of an advance directive nor related counseling to help patients complete the documentation properly.

> ⚙ **COVID-19 Considerations**
>
> Practices that have made operational changes or experienced a decrease in patient volume because of COVID-19 may use telehealth to meet the intent of this measure. POLST forms can be reviewed and signed electronically via telehealth.
>
> Please contact the PCPCH program at pcpch@oha.oregon.gov if you need further guidance.

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[52] See OHA's About the Oregon Physician Orders for Life-Sustaining Treatment (POLST) Program webpage for further information. End-of-life resources in Spanish and Chinese are also offered by the National Hospice and Palliative Care Organization and Chinese Community Health Resource Center, respectively.

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Standard 6.A
Meeting Language & Cultural Needs

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

Measures

Progressive – Select the level that best describes your practice (max 5 pts):

6.A.0	PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their language of choice.	**Must Pass**
6.A.1	PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic.	**5 points**

Intent of Standard 6.A

Cultural and linguistic proficiency 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 use trained health care interpreters.[53] Furthermore, providing culturally- and linguistically- appropriate written 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 helps to ensure that patients understand and follow written materials.

Definitions

Tele-interpretation: Language interpretation services provided remotely through methods such as telephone interpreting, TTY relay, video interpreting, or medical language interpretation software.

Specifications for 6.A.0

A practice is meeting measure 6.A.0 if it offers free-of-charge interpretation services to all patients at the practice 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. Whichever method of interpretation the practice uses should be delivered by a certified medical language interpretation software, program, or individual, depending on the practice's capacity and resources. Interpretation services must be available during a patients' 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

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[53] National Council on Interpreting in Health Care: <u>FAQ for Healthcare Professionals – Information about providing language access services.</u>

available free of charge and have distinct advantages. While not required, some practices ask patients who refuse interpretation services to sign a waiver.[54]

Examples:
- The practice uses a real-time telephonic interpreter[55] to communicate with patients in their language of choice throughout their entire office visit and/or during telephone encounters.
- The practice uses in-person interpreter(s) to communicate with patients in their language of choice throughout their entire office visit and/or during telephone encounters.
- The practice 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 practice has a subscription to a tele-interpretation service as a backup for patients that speak a language outside the scope of the bilingual staff.

Documentation Required at a Verification Site Visit:
Policy, procedure, or workflow demonstrating how practices provide services to patients in their primary language, which includes a list of interpreter services used at the practice (e.g., face-to-face, telephonic, bi-lingual staff, sign language, TTY)

🏅 **Best Practice**

Communicating with Patients

To best assess patients' language and communication needs, practices 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 used by your patient population.

Additionally, it is recommended that bilingual staff, interpreters, and translators be certified through a regulatory agency such as the Oregon Healthcare Interpreters Certification Program or the National Board of Certification for Medical Interpreters (NBCMI).[56] For additional information on interpreting/translating into plain language and effectively communicating with patients, please see the Joint Commission's (2010) resource: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.

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[54] The following policy memo contains additional information about Oregon's expectations around providing interpretation services in medical settings: Frequently Asked Questions Regarding Providing Interpreter Services to Individuals who are Deaf, Deaf-Blind, Hard of Hearing or Individuals with Limited English Proficiency

[55] Examples of telephonic interpreter services include Passport to Languages and LanguageLine Solutions.

[56] Visit the Oregon Health Authority Office of Equity and Inclusion Become a Qualified or Certified Healthcare Interpreter webpage for further guidance.

Activities that do not meet 6.A.0:
- A practice routinely relies on the family members of non-English speaking patients to act as interpreters without first offering them free clinic interpretation services.
- A practice uses google translate
- Interpreter services, providers, or other employees acting as interpreters are only available at certain times during practice business hours, but not available at other times. The practice 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.

Specifications for 6.A.1

A practice is meeting measure 6.A.1 if it provides vital and routinely used documents (printed and/or electronic) in all languages spoken by more than 30 households or the top two non-English languages of the practice's patient population, whichever the practice chooses to demonstrate.

Examples of vital documents:
- Registration forms
- New patient paperwork
- Consent forms
- Patient education materials
- POLST forms
- After visit summaries (AVS)

- Screenings for mental health/substance use disorder/developmental conditions
- Grievance policy
- Patient satisfaction surveys
- Clinic signage

Documentation Required at a Verification Site Visit:
1. Language utilization report of the practice's population. The practice must demonstrate with data the predominate languages, in addition to English, that are spoken by their patients, families, and caregivers. Predominate languages may be defined as either the top two non-English languages of the practice's population or those spoken by more than 30 households.
2. Examples of the practice's vital and routinely used materials available in those primary languages[57]

Activities that do not meet 6.A.1:
- A practice does not translate materials into any language other than English.
- A practice translates patient materials into languages other than English, but those languages are spoken by fewer than 30 households and are not the top two non-English languages spoken by the practice's patient population.
- A practice translates patient materials but does not use language utilization data to understand the languages spoken by its patient population.

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

Standard 6.B
Education & Self-Management Support

This is not a must-pass standard. Practices 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):

6.B.1	PCPCH provides patient-specific education resources to their patient population.	**5 points**
6.B.2	PCPCH provides patient-specific education resources and offers self-management support resources to their patient population.	**10 points**
6.B.3	PCPCH provides patient-specific education resources, offers self-management support resources to their patient population, and tracks utilization of multiple self-management groups.	**15 points**

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.

Relevant Definitions

Patient-specific education: A practice 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 practice 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, support groups, workshops/classes, and other chronic pain or stress management strategies.

Self-management groups: 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 practice itself or external organizations and service providers.

Unique patient: If a patient is seen more than once during the last 12 months, then that patient should only be counted once in the denominator for the measure.

Specifications for 6.B.1

A practice is meeting measure 6.B.1 if it is able to describe how it ensures that up-to-date patient-specific education resources are routinely provided to patients, families, and/or caregivers on a variety of topics that are relevant to the practice's diverse patient population. Although not required, it is ideal if educational resources are linguistically and culturally appropriate.

Examples:
- A practice provides patients reading information following a diabetes diagnosis about the causes, progression, lifestyle changes, and treatment options for this condition.
- A practice provides a caregiver online resources about normal childhood development during a well child check appointment.

Documentation Required at a Verification Site Visit:
Examples of 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 practice offers general patient educational resources to its entire patient population (such as a poster in the lobby) that are not specific to individual health needs of the patient.

Specifications for 6.B.2

A practice is meeting measure 6.B.2 if it is doing all of the following:

- ☑ It tracks and calculates how many patients, families, and/or caregivers receive patient-specific education resources. The resulting percentage must be 25% or more for the practice to meet this measure.
  - Numerator: Number of patients, families, and/or caregivers in the denominator who were provided patient-specific education resources during the last 12 months
  - Denominator: Number of unique patients seen by the practice during the last 12 months

- ☑ It offers or coordinates self-management support resources for patients which further their ability to effectively manage their health.

Example:

In order to promote healthy behaviors, a practice tracks that it provides patient-specific education to at least 25% of its patients regarding their specific condition, impactful behaviors, and age-appropriate anticipatory guidance. The practice also provides patients who have specific chronic conditions with home monitoring worksheets and connects diabetes patients with a local diabetes walking group.

Documentation Required at a Verification Site Visit:
1. EHR report or tracking list showing that 25% or more of unique patients received patient-specific education
2. Examples of the patient-specific education resources and self-management services that the practice provides to patients

Activities that do not meet 6.B.2:

The practice provides examples of patient-specific education resources and self-management services that are offered at the practice but is unable to demonstrate the 25% minimum requirement of unique patients who received patient-specific education resources and self-management services.

Specifications for 6.B.3

A practice is meeting measure 6.B.3 if it is doing all of the following:

- ☑ It tracks and calculates how many patients, families, and/or caregivers receive patient-specific education resources. The resulting percentage must be 25% or more for the practice to meet this measure.
  - Numerator: Number of patients, families, and/or caregivers in the denominator who were provided patient-specific education resources during the last 12 months
  - Denominator: Number of unique patients seen by the practice during the last 12 months
- ☑ It offers or coordinates self-management support resources for patients which further their ability to effectively manage their health.

- ☑ It offers or coordinates self- management groups and tracks its patients' utilization of these groups in order to understand engagement and identify barriers that may prevent patients from participating.

Examples:
- A practice runs reports quarterly to ensure at least 25% of its patient population is receiving patient-specific education regarding their specific condition. The practice also offers self-management resources to its patients who need extra support managing their chronic conditions. They have also started providing on-site self-management

groups and track the attendance of each group to determine what changes they can make to increase utilization of these groups.

- In addition to tracking and meeting the specified requirements for patient-specific education and offering self-management support to patients, a practice has recently partnered with the local gym to offer a balance and strengthen class for older adults that is facilitated by the gym twice a week. The practice tracks which patients have been given information about this class, and the gym send a list to the practice every week of the patients who participated in the class. The practice finds that there is one class that never has participation and the other is always full. They decide to change the time of the 2nd class during the week and have better utilization of the class.

🎗 **Best Practice**

Collaborating with Local Community Organizations

To best engage patients in self-management opportunities, PCPCHs interested in best practices 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 (THW) 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 practices in supporting their patients live a healthy and full life.

Documentation Required at a Verification Site Visit:
1. Examples of the patient-specific education resources offered at the practice
2. data showing that 25% or more of unique patients received patient-specific education
3. A list of self-management resources offered to patients at the practice
4. Tracker or log used for utilization of self-management groups or classes

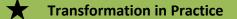**Activities that do not meet 6.B.3:**
The practice provides examples of patient-specific education resources offered to 25% or more of their patients, families and/or caregivers, as well as examples of self-management services provided. However, it does not track which patients participate in self-management support groups or classes.

Additional Resources:
Further information on patient-specific educational resources and self-management support services is available in the sources below:

- Take Control: www.healthoregon.org/takecontrol;
- Living Well: www.healthoregon.org/livingwell.

- Partnering in Self-Management Support - Toolkit for Clinicians:
  http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx
- Agency for Healthcare Research and Quality:
  https://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/sms_home.html

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★ **Transformation in Practice**

Meeting the Intent of all measures in 6.B

A primary care practice that serves a culturally and linguistically diverse patient population has struggled to help their newly diagnosed diabetic patients to understand their condition. In response, the practice 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 practice. ***These activities meet the intent of 6.B.1.***

In addition to offering patient-specific educational materials about diabetes to at least 25% of their patients, the practice offers self-management support by training its patients on how to effectively manage diabetes through home monitoring flowsheets and SMART goals. ***These activities meet the intent of 6.B.2.***

In addition to offering patient-specific educational materials to at least 25% of their patients and offering self-management support resources about diabetes, the practice 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. It also connects patients to local wellness opportunities, such as yoga classes, at a nearby community center. The practice tracks which patients attend Living Well with Chronic Disease classes, as well as patients who report attending yoga classes at a nearby community center. This information helps the practice target patients that would benefit from participating in self-management groups but have not yet attended any sessions. It also helps the practice ensure that the self-management resources remain relevant and accessible to their patient population. ***These activities meet the intent of 6.B.3.***

Standard 6.C
Experience of Care

This is a must-pass standard. Practices 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 15 pts):

6.C.0	PCPCH surveys a sample of its population on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness.	**Must Pass**
6.C.1	PCPCH surveys a sample of its population on their experience of care. The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. PCPCH also has a survey planning strategy in place and shares data with clinic staff.	**5 points**
6.C.2	PCPCH surveys a sample of its population on their experience of care using one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).	**10 points**
6.C.3	PCPCH surveys a sample of its population on their experience of care using one of the CAHPS survey tools, meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).	**15 points**

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 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.

Using one of the CAHPS survey tools (version 2.0 and 3.0) is recommended for measures 6.C.0 and 6.C.1 and required for measures 6.C.2 and 6.C.3.

Relevant Definitions

***Patient Panel*:** The group of patients that are assigned to an individual provider in the practice'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.[58]

Specifications for 6.C.0

A practice 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:

☑ Practice surveys patients directly or through a third-party vendor. Surveys are collected on paper, via telephone, or electronically.

☑ Practice 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 for measure 6.C.0 and 6.C.1 and can be used as a resource when brainstorming survey questions around these subjects.[59]

☑ Practice obtains survey results from at least 3 percent of each primary care provider's assigned patient panel. All primary care providers with a patient panel at the practice 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 practice for less than 6 months from the time the survey was administered are exempt from survey data analysis. The table below demonstrates the number of surveys that must be returned per provider based on different sized patient panels.

Individual Providers Assigned Patient Panel	Minimum 3% Survey Return Rate Required Per Provider
2,250 patients	68 surveys
1,500 patients	45 surveys
1,050 patients	32 surveys

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[58] See Standard 4.A.0 for definition of "active patient."

[59] CAHPS Survey tools are available to the public at no cost from the Agency for HealthCare Research and Quality (AHRQ) and can be accessed at https://cahps.ahrq.gov/surveys-guidance/index.html. The CAHPS Clinician and Group Survey with Patient-Centered Medical Home items is recommended, which can be found at *http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/index.html.*

☑ Practice 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.

☑ Practice routinely shares survey results with staff.

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.
3. Evidence of the survey results being routinely shared with staff (e.g. PowerPoint presentations, meeting minutes, etc.)

🎗 **Best Practice**

Conducting Patient Experience of Care Surveys

PCPCHs interested in implementing best practices can follow these additional specifications:

- 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.)
- Try for a 6% response rate for each provider's assigned patient panel.
- Include patients who have had at least one visit in the target time frame (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 practice, 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 and alternative formats and take health literacy into account based on clinic's patient population.

Activities that do not meet 6.C.0:
- The practice does not collect the minimum survey requirement of 3% of each primary care provider's patient panel within the two-year survey period.
- The practice is able to present clinic-level data but unable to review data on an individual provider level.
- The 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.
- The practice collects survey data but does not share the survey results with its staff.

Specifications for 6.C.1

A practice is meeting measure 6.C.1 if it meets all the specifications for 6.C.0 and has a robust survey strategy that includes survey timelines, target response rates, outcome goals, and other tactics to improve the survey experience and make the process meaningful.

Example:
A practice 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 a survey strategy with the goal of increasing the number of surveys returned per provider. They define 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 practice 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.

Documentation Required at a Verification Site Visit:
1. Copy of the paper or electronic survey 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.
3. Written survey strategy including goals, timelines, target response rate, and staff engagement
4. Evidence that demonstrates how the survey results are routinely shared with staff (e.g. PowerPoint presentations, meeting minutes, etc.)

Activities that do not meet 6.C.1:
- The practice has a survey strategy to improve their survey processes, but it is not utilized as intended or maintained.
- The practice does not share survey results or survey data with staff.

Specifications for 6.C.2

A practice is meeting measure 6.C.2 if it is doing all of the following:

☑ Meets all the specifications for 6.C.0

☑ Uses one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools

☑ Utilizes a survey strategy that includes survey timelines, target response rates, survey outcome goals, and other tactics to improve the survey experience and make the process meaningful

☑ Uses CAHPS survey data for quality improvement activities.

Practices can use either the 2.0, 3.0 or the 3.1 CAHPS survey version.[60] Version 3.0 has fewer questions than the 2.0 version and incorporates a 6-month look back rather than the 12-month lookback in version 2.0. Version 3.1 is the newest version and has survey participants consider their in-person, phone, and video visits when answering the questions.

Example:
A practice has two providers, each with a small patient panel. Collecting the required number of returned surveys has not been difficult for them. Although their survey strategy does include survey response rates and timelines, the focus of their strategy is on utilizing the CAHPS survey feedback to meet annual quality improvement project goals. When the quality team meets to discuss survey results, they find that "Helpful, Courteous, and Respectful Office Staff" is their lowest scoring CAHPS domain. Through Plan, Do, Study, Act (PDSA) cycles, they develop training for staff to address the issues and continue to share results at their all-staff meetings.

Documentation Required at a Verification Site Visit:
1. Copy of paper or electronic CAHPS survey used to collect patient feedback
2. Provider-level survey data for each CAHPS survey domain. This must include survey dates, panel size, and the response rate for each provider.
3. Written survey strategy including goals, timelines, target response rate, and staff engagement
4. Evidence demonstrating how the survey results are routinely shared with staff (e.g. PowerPoint presentations, meeting minutes, etc.)
5. Demonstration of how practice utilized CAHPS survey results in a quality improvement process

Activities that do not meet 6.C.2:
- The practice does not use a qualifying CAHPS survey version.
- The practice is unable to explain how survey results are utilized in a quality improvement process.
- The practice does not have a documented survey strategy that includes the required elements.
- The practice collects survey data but does not share survey results with staff.

Specifications for 6.C.3

A practice is meeting measure 6.C.3 if it is doing all of the following:

- ☑ Meets all the specifications for 6.C.0
- ☑ Uses one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools

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[60] Differences between version 2.0 and 3.0 can be found here:
https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf

☑ Utilizes a survey strategy that includes survey timelines, target response rates, survey outcome goals, and other tactics to improve the survey experience and make the process meaningful.

☑ Shares survey data with both staff and patients.

☑ Uses CAHPS survey data for quality improvement activities.

☑ Meets the most recent Top Box Score (75th percentile) benchmark available[61] or demonstrates intentional improvement on a majority of CAHPS survey domains. Intentional improvement can be demonstrated by showing that the previous CAHPS survey data/responses were used to inform strategies that led to improvement in selected domains.

Practices can use either the 2.0, 3.0 or 3.1 CAHPS survey version.[62] Version 3.0 has fewer questions than the 2.0 version and incorporates a 6-month look back rather than the 12-month lookback in version 2.0. Version 3.1 is the newest version and has survey participants consider their in-person, phone, and video visits when answering the questions.

Calculating your Practice's Top Box Scores:
Your practice's Top Box Score for a given domain is the percentage of respondents who chose the most positive score on the response scale (e.g. "Always" on the "Always-Never" scale) for each of the questions the respondent answered within that domain. This percentage (your Top Box Score) is what you will compare to the 75th percentile to determine if you've met the Top Box Score benchmark for that domain.

For example, there are two questions in the "Helpful, Courteous, and Respectful Office Staff" domain[63] within the Clinician and Group Survey. If 30 patients answer the first question, and 20 of them choose the most positive response (i.e. always), the proportion for that question is 67%. If 20 patients responded to the second question and 10 of them choose the most positive response (i.e. always), the proportion for that question is 50%. To calculate the overall domain Top Box Score, you would take the average of the first and second question proportions, meaning (67 + 50) ÷ 2 = 59. The top box score for the "Helpful, Courteous, and Respectful Office Staff" domain would therefore be 59%. If this were equal or greater than the 75th percentile for that domain, then this has met the benchmark for that domain.

Note: For the "Provider Rating" domain, the Top Box Score is the percentage of respondents who marked either 9 or 10 on the 1-10 rating scale.

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[61] To find the most recent available Top Box Score benchmark for each domain in the CAHPS Adult 3.0 survey version, navigate to the link https://datatools.ahrq.gov/cahps, select "CAHPS Clinician & Group Survey Database", click on the "Percentiles" tab, and find the 75th percentile column. For the Adult 2.0 and Child CAHPS Survey versions, see the table on page 137 of this guide.

[62] Differences between version 2.0 and 3.0 can be found here: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf

[63] Sometimes referred to as the "Clerks and receptionists at provider's office" domain.

Most Recent "Top Box" Scores (75th percentile) for Select CAHPS Survey Domains:

Core Domains plus PCMH Domain	Adult Survey 2.0 (2015 scores)	Child Survey 2.0 (2014 scores)	Child Survey 3.0 (2016 scores)
Getting timely appointments, care, and information	70%	76%	81%
Provider Communication (How well providers communicate with patients)	94%	91%	94%
Helpful, courteous, and respectful office staff	95%	82%	84%
Follow-up on test Results	90%	87%	NA
Provider rating	87%	87%	89%
Providers' use of information to coordinate patient care	NA	NA	85%
(PCMH domain) Providers support you in taking care of your child's health	NA	44%	NA
(PCMH domain) Attention to your child's growth and development	NA	NA	75%

Example:

A practice meets the benchmark on the majority of domains in the CAHPS survey version it uses. They have a robust survey strategy that has helped them excel in their survey response rates per provider, achieve high patient satisfaction rates, and meet other goals set by the practice. Their survey data has inspired a quality improvement project to improve in-person access by adding two additional same-day openings on each providers schedule. This is shared with the practice staff during a slide show presentation and posted in the lobby to share with patients.

Documentation Required at a Verification Site Visit:
1. Copy of paper or electronic CAHPS survey used to collect patient feedback
2. Written survey strategy including timelines, target response rate, staff engagement, and intentional improvement goals (if needed)
3. Provider-level survey data for each domain. This must include survey dates, panel size, and the response rate for each provider. This data must demonstrate that the practice has improved on or is meeting the benchmark on a majority of the CAHPS survey domains
4. Documentation demonstrating how practice utilized CAHPS survey results in a quality improvement process
5. Evidence demonstrating how survey results are routinely shared with staff (e.g. PowerPoint presentations, meeting minutes, etc.)
6. Demonstration of how the survey results are routinely shared with patients such as waiting or exam room posters/visuals, website, or flyers/mailed materials

Activities that do not meet 6.C.3:
- The practice is unable to show intentional improvement or meet the benchmark on a majority of the CAHPS domains.
- The practice is unable to demonstrate the utilization of the survey results in a quality improvement process.
- The practice does not have a documented survey strategy.
- The survey results are not shared with practice staff and patients.

★ **Transformation in Practice**

Demonstrating Intentional Improvement within the Survey Strategy

A practice meets the benchmark on three out of five CAHPS domains and intends to demonstrate intentional improvement on a fourth domain to meet the requirement for measure 6.C.3. "Follow up on Test Results" was one of their domains that did not meet the benchmark.

The practice develops a comprehensive survey strategy that, along with minimum survey responses per provider and outcome goals for each domain, includes a focus on utilizing previous survey data to improve scores for the "Follow up on Test Results" domain. They have set a specific goal of an increase of four percent within 12 months. As a result, the quality team works with three medical assistants to re-evaluate the workflow for following up with patients on test results, including new goals for the amount of time it takes to return a phone call to patients about their test result(s). Six months after implementing the new workflow and in accordance with their survey strategy, survey results demonstrate a small improvement in the "Follow up on Test Results" domain, and the practice continues to monitor and evaluate their improvement over the year. This is shared with the practice staff during a slide show presentation and within a patient newsletter.

The improvement plan within the survey strategy, PDSA cycles, the monitoring and evaluation of survey results, and the slide show presentation are ways the practice can demonstrate intentional improvement on the "Follow upon Test Results" domain.

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Standard 6.D
Communication of Rights, Roles & Responsibilities

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This is not a must-pass standard. Practices 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

6.D.1	PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.	**5 points**

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 the following outcomes: 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.1

A practice is meeting measure 6.D.1 if it provides every patient with a brochure or handout—either upon checking in for their first visit or by mail before their first visit. The brochure or handout 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[64]

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[64] 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).

Documentation Required at a Verification Site Visit:
Copy of the document or educational materials used

Activities that do not meet 6.D.1:
The practice only provides the HIPAA grievance policy within its materials rather than a complete practice-specific grievance policy and description of patients' rights.

Adult Quality Measure Set

Measure #	Measure Language	Benchmark*
1	BMI Screening and Follow-up	90%
2	Tobacco Use: Screening and Cessation Intervention	82%
3	Breast Cancer Screening Ages 50-74	64%
4	Cervical Cancer Screening	78%
5	Colorectal Cancer Screening	62%
6	Comprehensive Diabetes Care: Hemoglobin poor Control (>9.0%)	23%
7	Screening for Clinical Depression	63%
8	Controlling High Blood Pressure	67%
9	Influenza Vaccination	46%
10	Pneumonia Vaccination for Older Adults	81%
11	Chlamydia Screening in Women Ages 16-24	66%
12	Depression Response at 6 Months – Progress Towards Remission	TBD
13	Coronary Artery Disease (CAD): Antiplatelet Therapy	TBD
14	Prenatal and Postpartum Care- Prenatal Care Rate	69%
15	Statin Therapy for Patients with Diabetes	67%
16	Statin Therapy for Patients with Cardiovascular Disease	81%
17	Initiation and Engagement of Alcohol and other Use Disorder treatment	IET Initiation: 46.8% IET Engagement: 18.5%

Pediatric Quality Measure Set

Measure #	Measure Language	Benchmark*
18	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	30%
19	Childhood Immunization Status (Combo 7)	63%
20	Measure AWC-CH Adolescent Well-Care Visits (12-21 years)	63%
21	Developmental Screening in the First 3 Years of Life	74%
22	Well Child Care (0 – 15 months)	75%
23	Well Child Care (3 – 6 years)	78%
24	Measure AMR-CH Asthma Medication Ratio	68%
25	Follow-up Care for Children Prescribed ADHD Medication	56% initiation 69% continuation and maintenance
26	Adolescent Immunizations up to Date at 13 Years Old (Combo 2)	40%

* Practices using the OHA CCO Incentive Measures specifications rather than the original measure steward may use the associated OHA benchmarks.

1. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan PCPCH Adult Quality Measure Set

Description:

Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter

Normal Parameters: Age 18 years and older BMI >= 18.5 and < 25 kg/m2

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 90%

2. Tobacco Use: Screening and Cessation Intervention
PCPCH Adult Quality Measure Set

Description:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 82%

3. Breast Cancer Screening
PCPCH Adult Quality Measure Set

Description:

Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 64%

4. Cervical Cancer Screening
PCPCH Adult Quality Measure Set

Description:

Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 78%

5. Colorectal Cancer Screening
PCPCH Adult Quality Measure Set

Description:

Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 62%

6. Comprehensive Diabetes Care: Hemoglobin poor Control (>9.0%)
PCPCH Adult Quality Measure Set

Description:

Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 23%

7. Screening for Clinical Depression
PCPCH Quality Measure Set

Description:

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 63%

8. Controlling High Blood Pressure
PCPCH Adult Quality Measure Set

Description:

Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 67%

9. Influenza Vaccination
PCPCH Adult Quality Measure Set

Description:

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 46%

10. Pneumonia Vaccination for Older Adults
PCPCH Adult Quality Measure Set

Description:

Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 81%

11. Chlamydia Screening in Women Ages 16-24
PCPCH Quality Measure Set

Description:

Percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 66%

12. Depression Response at 6 Months – Progress Towards Remission
PCPCH Adult Quality Measure Set

Description:

Percentage of Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.

This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period who's current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: TBD

13. Coronary Artery Disease (CAD): Antiplatelet Therapy
PCPCH Adult Quality Measure Set

Description:

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who were prescribed aspirin or clopidogrel

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: TBD

14. Prenatal & Postpartum Care
PCPCH Adult Quality Measure Set

Description:

Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 69%

15. Statin Therapy for Patients with Diabetes
PCPCH Adult Quality Measure Set

Description:

Percentage of adults 40-75 years of age who have diabetes and who do not have clinical ASCVD, who received and adhered to statin therapy

Specifications:

To access the technical specifications for this measure:

1) Visit the NCQA website.
Go to https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 67%

16. Statin Therapy for Patients with Cardiovascular Disease
PCPCH Adult Quality Measure Set

Description:

Percentage of males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy

Specifications:

To access the technical specifications for this measure:

1) Visit the NCQA website.
Go to https://www.ncqa.org/hedis/measures/statin-therapy-for-patients-with-cardiovascular-disease-and-diabetes/

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 81%

17. Initiation and Engagement of Alcohol and other Use Disorder treatment
PCPCH Adult Quality Measure Set

Description:

This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported:

- Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate:

IET Initiation - Total Age 18+: **46.8%**

IET Engagement - Total- Age 18+: **18.5%**

18. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
PCPCH Pediatric Quality Measure Set

Description:

Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:

- Body mass index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 30%

19. Childhood Immunization Status (Combo 7)
PCPCH Pediatric Quality Measure Set

Description:

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); and two or three rotavirus (RV) vaccines by their second birthday. The measure calculates a rate for each vaccine.

(These are the requirements for the Combo 7 vaccine series)

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:

> PQM - https://p4qm.org/measures
> > - If using this link, do not include influenza vaccination rates in the specifications for this measure. We are looking for the Combo 7 vaccination requirements listed above.

> CCO Incentive Metrics - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx
> > - If using this link, can use the Combo version that aligns with the current CCO Incentive Metric specifications

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 63%

20. Adolescent Well-Care Visits (12-21 years)
PCPCH Pediatric Quality Measure Set
Medicaid/CHIP Child Core Set

Description:

Percentage of patients age 12-21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB-GYN practitioner during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit OHA CCO Incentive Metrics website.
CCO Incentive Metrics - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 63%

21. Developmental Screening in the First 3 Years of Life
PCPCH Pediatric Quality Measure Set

Description:

Percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 74%

**22. Well-Child Visits in the First 15 Months of life
PCPCH Pediatric Quality Measure Set**

Description:

Percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 75%

23. Well Child Care (3 – 6 years)
PCPCH Pediatric Quality Measure Set

Description:

Percentage of children 3-6 years of age who had one or more well-child visits with a primary care physician during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 78%

24. Measure AMR-CH Asthma Medication Ratio
PCPCH Pediatric Quality Measure Set

Description:

Percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement website:
Go to https://p4qm.org/measures

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 68%

25. Follow-up Care for Children Prescribed ADHD Medication
PCPCH Pediatric Quality Measure Set

Description:

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate:

Initiation: **56%**

Continuation and maintenance: **69%**

26. Immunizations for Adolescents
PCPCH Pediatric Quality Measure Set

Description:

Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday

Specifications:

To access the technical specifications for this measure:

1) Visit the Partnership for Quality Measurement or the OHA CCO Incentive Metrics website:
PQM - https://p4qm.org/measures
CCO Incentive Metric - https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

2) Print out the specifications for the quality measures you are planning to report on.

3) Calculate your clinic's data according to the specifications.

4) Keep the specifications you are using and your data summaries along with your other PCPCH application documentation.

Benchmark rate: 40%

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.

Care Coordination: Care coordination is 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. (AHRQ, 2014)

> **Coordination of Services** - A practice 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 practice. Examples include, but are not limited to:
> - Care coordination functions listed in the best practice box in 5.C (p. 110)
> - Initiating and/or tracking referrals to specialty providers or community organizations
> - Collaborating with external providers or organizations on services
> - Designating care coordinators within the practice
>
> **Care coordinators:** One or more staff members who are responsible for the provision and coordination of services for the practice'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 practices can conduct to assess their own activities and performance. Practices may use chart audits for practice improvement, self-assessment, or (in select standards) to submit data to the PCPCH program that cannot be produced by 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 (4.A and 4.B) 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 practice 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 practice 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.

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

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 by the Centers for Medicare and Medicaid Services (CMS). 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 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.

Practices can take steps to advance health equity through efforts such as:
- Increasing practice 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

Integration of services: A service has been integrated into a practice if the practice 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 practice if they meet **all** of the following criteria:
- Are co-located with the practice 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 practice 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

Patient Education (Health Education): A practice 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. practice 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 practice engages in referrals when it directs a patient to a specialist, service, or organization external to the practice. Different standards have different expectations around referrals.

> **Cooperative/collaborative referrals:** Practice has a partnership or cooperative agreement with a specialist or organization which involves two-way communication regarding patients' referral status (ex: organization sends monthly list to practice with patients that received referred services).
>
> **Referral follow-up:** A practice 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 practice 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 practice 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, support groups, workshops/classes, and other chronic pain or stress management strategies. Different standards have different expectations around self-management support services.

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, the 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): An umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. There are five specialty types of THWs:
- Birth Doulas
- Personal Health Navigators (PHN)
- Peer Support Specialists (PSS)
- Peer Wellness Specialists (PWS)
- Community Health Workers (CHW)

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).