

Oregon Health Authority Patient-Centered Primary Care Home 2020 Recognition Criteria Technical Specifications and Reporting Guide (TA Guide)

September 2020 Revisions Summary

Introduction

The Oregon Health Authority (OHA) revises the Patient-Centered Primary Care Home (PCPCH) recognition standards periodically to incrementally adapt the PCPCH model to the changing health care priorities of the state, align the model with the best evidence where it is available and improve the effectiveness of the standards and measures overall. Revisions are based on the recommendations of the [PCPCH Standards Advisory Committee](#), feedback from subject matter experts and stakeholders, and alignment with Oregon's health system transformation goals. The 2020 PCPCH recognition standards are described in detailed in the [Oregon Health Authority Patient-Centered Primary Care Home 2020 Recognition Criteria Technical Specifications and Reporting Guide](#) (TA Guide).

This document is an overview of the changes from the 2017 PCPCH recognition standards. Key changes include:

- Revisions to existing standards;
- New standards;
- Improving health equity in the PCPCH model;
- 5 STAR designation criteria;
- Tier level point distribution;
- NCQA recognized practices; and
- COVID-19 considerations.

The 2020 PCPCH recognition standards will go into effect on January 1, 2021. All practices applying or re-applying for PCPCH recognition after this date will be held the 2020 model.

Revisions to Existing Standards

Standard 1.A: In-Person Access

Standard 1.A was revised to focus on tracking and improving timely access to and communication with clinical staff instead of surveying patients. It now includes two measures instead of three, reducing the maximum points available for the measure from 15 to 10 points.

Standard 1.E: Electronic Access

In lieu of changes to the CMS EHR Incentive Program (Meaningful Use), Standard 1.E was revised to include all types of electronic access and no longer includes the 10 percent minimum that was required through Meaningful Use objectives.

Standard 2.A: Performance & Clinical Quality

Measure 2.A.0 (a must-pass standard) now requires that practices track and report to the OHA three PCPCH Quality Measures instead of one. Measure 2.A.1 was revised to center around value-based payment arrangements, and Measure 2.A.3 was revised to encourage and reward continual improvement on quality metrics. OHA updated the quality metrics set and eliminated the division of metrics into “core” and “menu.” The overall standard was also changed to “check all that apply”, increasing the maximum points available for the measure from 15 to 20 points.

Standard 2.B: Public Reporting

Standard 2.B.1 and 2.B.2 were combined into one measure (2.B.1), reducing the maximum points available for the measure from 10 to 5 points.

Standard 2.E: Ambulatory Sensitive Utilization

Measure 2.E.1 was revised to center around value-based payment arrangements. Measure 2.E.2 was revised to reward clinic processes that address adverse or unexpected utilization patterns, ensuring that the utilization metrics are broad enough to apply to clinics with smaller patient populations or with limited access to claims data. This standard is also now a check-all-that-apply since clinics can meet the proposed measures independently, for a new maximum total of 30 points instead of 15 points.

Standard 3.B: Medical Services

Standard 3.B was revised to include CDC-recommended, age-appropriate immunizations to the list of primary care services that all PCPCHs must make available. Practices that cannot provide recommended vaccines onsite are required to show evidence of closed-loop referrals to partnering organizations to demonstrate that appropriate coordination of this service is provided.

Standard 3.C: Behavioral Health Services

Measure 3.C.2 was reduced to 5 points (becoming 3.C.1) and replaced with a new 3.C.2 which rewards practices that provide pharmacotherapy and recovery support to patients with substance use disorders. The standard is now worth 30 points instead of 25 points, due to the addition of a 3.C.1.

Standard 3.D: Comprehensive Health Assessment & Intervention

Standard 3.D was revised to focus on rewarding practices that assess their patients for health-related social needs and seek to address them. It was expanded to include three measures instead of one, resulting in a new maximum 15 points available for the measure instead of 5 points.

Standard 3.E: Preventive Services Reminders

Standard 3.E.1 is no longer as innovative today as it was in the past. Accordingly, Standard 3.E.1 was removed from Standard 3.E.

Standards 4.C.0

Standard 4.C.0 (a must pass standard) was revised to require all PCPCHs to utilize a CMS-certified EMR.

Standard 4.D: Clinical Information Exchange

Measure 4.D.2 (10 points) was added to this standard to recognize practices that exchange clinical information electronically but do not have the bi-directional, real time electronic exchange.

Standard 4.G: Medication Reconciliation and Management

In lieu of changes to the CMS EHR Incentive Program (Meaningful Use), Measure 4.G.1 was removed from the standard. Measure 4.G.2 was revised to focus on providing medication reconciliation for those most in need of this service (i.e., patients with complex or high-risk medication concerns), rather than tracking the percentage of total patients that receive this service. Similarly, Measure 4.G.3 was revised to focus on providing Medication Management to patients with complex or high-risk medication concerns.

Standard 5.B Electronic Health Record

Standard 5.B was removed from the model. Language from this standard was incorporated into Standard 4.C of the new model.

Standard 5.C: Complex Care Coordination

Measure 5.C.3 was revised to incorporate a broader array of care plan components for clinics to choose from and to reflect a more collaborative process that positions patients at the center of their care plan development.

Standard 5.E: Referral & Specialty Care Coordination

The list of specialized settings in Measure 5.E.3 was revised to include both adult or child foster care, traditional health workers, school-based health centers, and behavioral health providers and organizations.

Standard 6.A: Language/Cultural Interpretation

Measure 6.A.1 no longer has the “5% of a practice’s patient population” threshold and instead requires that clinics translate materials into language(s) spoken by more than 30 households or the top 2 non-English languages of the clinic’s patient population.

Standard 6.B: Education & Self-Management Support

Measure 6.B.2 was revised to include self-management support resources and a 25% minimum threshold for the proportion of patients provided patient-specific education resources. This minimum has also been applied to 6.B.3, which also requires practices to track utilization of multiple self-management groups in addition to the activities in 6.B.2. The measure also encourages clinics to leverage existing community programs in cases where these are of high quality and/or preferred by patients.

Standard 6.C: Experience of Care

OHA added a 5-point measure to Standard 6.C (6.C.1) with similar expectations as 6.C.2, but without the CAHPS requirement. Additionally, Standard 6.C was revised to require all clinics to share data with staff and collect surveys from 3% of each provider's patient panel instead of the previous 25-per-provider minimum threshold. Measures 6.C.2 and 6.C.3 were revised to include a survey planning strategy. Additionally, practices that attest to Standard 6.C.3 must now share survey data with patients and can demonstrate intentional improvement on a CAHPS domain rather than meeting a benchmark.

New Standards

Standard 1.G: Alternative Access

Standard 1.G is a new standard with two measures that have been added to the model to recognize practices that offer alternative office visit types to their patients. This new standard is a check-all-that-apply standard and has a maximum of 15 points.

Standard 2.F: PCPCH Staff Vitality

Standard 2.F is a new standard with two measures that have been added to the model to recognize clinics engaged in activities that support the safety, well-being, work satisfaction, growth and overall morale of their staff. This new standard has a maximum of 10 points.

Standard 3.F: Oral Health Services

Standard 3.F is a new standard with three measures that have been added to the model to recognize clinics that assess for oral health needs and facilitate access to appropriate treatment. This new standard has a maximum of 15 points.

Improving health equity within the PCPCH model

In response to feedback and suggestions from multiple stakeholders including Ignatius Bau—a nationally recognized health care policy consultant for equitable and patient-centered care—the standards and overall model have been revised to promote health equity. Suggestions centered around understanding the diversity of patients served, engaging patients (and their families/caregivers) in their own health care, meeting the communication needs of diverse patients, providing team-based care to diverse patients, addressing the social determinants of health and integrating the reduction of disparities into quality improvement and practice transformation. These suggestions were integrated into the language of standards 2.C, 5.A, 5.C, 5.D, and 6.A. These concepts were also incorporated into examples and best practices within other standards.

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

Standard 2.C was revised to replace “patient-defined families” with the word “families” and provide definitions of “families” and “caregivers” as inclusive of any party defined and designated by the patient. The standard includes instructions on documenting appropriate Health Insurance Portability and Accountability Act (HIPPA) waivers, powers of attorney and other legal authorizations to share personal health information with patient-defined and designated family members and caregivers.

Standard 5.A: Population Data Management

PCPCHs must include their entire patient population in their population data management activities.

Standard 5.C: Complex Care Coordination

Standard 5.C includes “patient-defined and designated family caregivers” in 5.C.1 and “diverse” in 5.C.2 and 5.C.3. The technical specifications include a list of examples for the definition of “diverse.”

Standard 5.D: Test & Result Tracking

Standard 5.D includes “caregivers” and requires an explanation of test results to patients, family members or caregivers.

Standard 6.A: Language/Cultural Interpretation

Standard 6.A has been revised to read “Meeting Language and Cultural Needs.” The 2020 TA Guide distinguishes between equality and equity, as well as instructions or explicit examples for various standards on how to improve the equity of their processes.

5 STAR designation criteria

In response to changes and additions to the PCPCH model standards, the measures included in the 5 STAR menu have been revised and the list expanded from 13 to 16 measures. OHA will keep the threshold at 80% – meaning clinics would need to meet 13 out of 16 measures to qualify for 5 STAR recognition, instead of 11 out of 13 measures.

Tier level point distribution revisions

The revisions to the standards and measures has increased the total points available to clinics from 380 to 430 points.

The table below shows the new point thresholds for each tier:

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

NCQA-recognized Practices

In 2017, NCQA PCMH eliminated their levels (or tiers), which has resulted in the following changes to the abbreviated application process for NCQA-recognized practices:

- 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.

COVID-19 CONSIDERATIONS

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. The 2020 TA Guide includes alternative technical specifications practices may use to meet the intent of the identified standards.