Patient-Centered Primary Care Home Program
Proposed Revisions Summary

How the revisions were developed

The Oregon Legislature created the Oregon Health Authority (OHA) Patient-Centered Primary Care Home (PCPCH) Program in 2009 as part of a comprehensive statewide strategy for health system transformation. The PCPCH Program develops primary care delivery standards in partnership with an advisory committee and certifies practices in Oregon that meet those standards. The committee is reconvened periodically to review PCPCH implementation progress and to refine the standards. There are over 600 primary care practices recognized as PCPCHs.

The PCPCH Program is committed to supporting a primary care delivery system that meets the needs of everyone living in Oregon, including people who experience systemic racism, barriers in accessing care, and health inequities. The 2022 PCPCH Standards Advisory Committee (Committee) made recommendations to OHA on how to advance and support equity in the PCPCH standards. The Committee met nine times from July 2022 to February 2023, and a report with the recommendations was published in April 2023. This document is a summary of the committee's recommendations, which OHA plans to adopt in the next iteration of the PCPCH standards in 2024.

The Committee's recommendations were informed by listening sessions that program staff conducted in 2021 with over 25 community-based organizations and primary care practices serving a diverse patient population statewide, as well as an analysis of existing data, reports and dashboards. The PCPCH Program published a report describing the community input process and a summary of the findings. In addition, PCPCH Program staff consulted with health equity and policy expert Ignatius Bau, JD throughout the Committee's 2022 convening to ensure alignment with national best practices for equity-centered primary care.

Revisions to the 2020 PCPCH Standards

Strengthening the existing PCPCH standards and measures:

There are 35 PCPCH standards in the model each with up to three measures that demonstrate how a practice is implementing the standard. The PCPCH program will be revising many existing standards and measures to advance and improve health equity. Notable revisions include guidance and support for practices with regards to:

- Providing patients with access to telehealth services in their primary language.
- Documenting patients' race, ethnicity, language, disability, sexual orientation, or gender identity in the electronic health record.
- Assisting patients in navigating the cost and payment options of their care.

- Assuring that referrals and patient education materials are culturally and linguistically appropriate for the patient.

The proposed revisions to the PCPCH Standards are included at the end of this document.

New PCPCH must-pass measures:

There will be three new must-pass measures that all PCPCHs will be required to meet. These additional must-pass measures increase the total from 11 to 13 (two current must-pass measures were combined). The additional must-pass measures are:

- **4.F.0** - PCPCH has a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available.
- **6.D.0** - PCPCH has a written document or other educational materials that outlines PCPCH and patient rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.
- **6.E.0** - PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.

New PCPCH standards:

Three new optional standards will be included in the PCPCH model:

- **A Value-Based Payment (VBP) standard** designed to align with Oregon's focus on transitioning away from traditional fee-for-service (FFS) payment models to VBPs that can support PCPCH's team-based care and care management efforts.
- **A health care cost navigation standard** that will encourage PCPCHs to share cost information with their patients and help them navigate payment options for their care.
- **A building a culturally responsive workforce standard** that will require PCPCHs to ensure that their staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care, and encourage PCPCHs to utilize traditional health workers in their care delivery.

Special designations:

The PCPCH program will introduce a new special designation and retire a current designation:

- **A new Health Equity Designation** will be created to encourage PCPCHs to prioritize supporting health equity for their patients in their practices. A PCPCH at any tier level is eligible to apply for the designation. To meet this designation, a PCPCH must attest to 15 out of 20 health equity-focused measures and submit all required documentation for these measures at the time of application. PCPCH program staff will review the submitted documentation to determine if the PCPCH is meeting the health equity designation criteria before the designation is awarded. The Health Equity Designation measures are noted on the revised PCPCH Standards at the end of this document.

- **Retiring 5 STAR designation:** The 5 STAR designation will be replaced with a Tier 5 that is point-based like Tiers 1-4. The 5 STAR designation was created in 2014 as a way for PCPCHs to distinguish themselves from other PCPCHs by meeting multiple advanced measures in the model. However, over time it has become clear that the designation is not necessarily the marker of a high-performing primary care practice that it was intended to be. For many small, rural, and pediatric PCPCHs, 5 STAR is not achievable because the practices lack the resources, capacity, and infrastructure to meet the multiple advanced measures needed for the designation. Consequently, this change was made to ensure all practices have the capacity to achieve the highest PCPCH tier.

Tier point distribution:

The program will restructure the tier levels to make the point distribution more equitable and better incentivize quality improvement. Each measure in the PCPCH Standards is assigned a value of 5, 10 or 15 points. Primary care practices attest to meeting measures in the standards and their PCPCH tier level is determined by the total point value of the measures they attested to. In the upcoming revised PCPCH Standards, points for each tier level will be evenly distributed so that PCPCHs that have attested to a similar number of measures (points) have the same tier level.

The current point distribution for PCPCH tier levels is skewed so that the top tier levels have the largest point distribution. For example, while a PCPCH that attests to measures totaling 255 points is meeting significantly fewer measures than a PCPCH that attests to 430 points, both are a Tier 4. This uneven point distribution structure has resulted in 81% of PCPCHs achieving a Tier 4 or 5 STAR. There are currently no PCPCHs at Tier 1 or Tier 2. The PCPCH tier structure was designed as a framework to encourage transformation and quality improvement. Under the current tier point distribution, once PCPCHs reach the Tier 4 level, there is little incentive for them to attest to additional measures or seek opportunities to advance.

Current 2020 PCPCH Tiers			**Revised PCPCH Tiers**		
Tier Level	**Point Range**	**Point Distribution**	**Tier Level**	**Point Range**	**Point Distribution**
Tier 1	30 – 60	30 points	Tier 1	60 – 150	90 points
Tier 2	65 – 125	55 points	Tier 2	155 – 245	90 points
Tier 3	130 – 250	120 points	Tier 3	250 – 340	90 points
Tier 4	255 – 430	175 points	Tier 4	345 – 435	90 points
5 STAR	255 – 430	175 points	Tier 5	440 – 530	90 points

It is difficult to estimate how this point redistribution will impact any specific PCPCH's tier level since all practices attest to different measures, and the revised standards will have more total measures and flexible expectations for some existing measures. However, it likely that some practices will experience a reduction in their tier level if they do not attest to any additional measures under the revised standards. It is important for payers, providers, patients, community partners and others to understand that if a practice experiences a tier reduction under the revised standards it does not necessarily mean that they are meeting fewer measures. Coordinated Care Organizations (CCOs) and other payers with payment models based on PCPCH tier levels should continue to sustain current payment amounts to all PCPCHs so there is no loss in payment because of a tier level change due to the point distribution adjustment in the revised PCPCH Standards.

Implementation Timeline (subject to change)

The PCPCH program is continuing to gather feedback about the revised PCPCH Standards from community partners, patients, providers, payers and other interested parties. Feedback is welcome at any time by emailing the program at PCPCH@OHA.oregon.gov

In Fall 2023, these revisions will be adopted in Oregon Administrative Rule. This process will include a public hearing for additional feedback before the revisions are finalized. To receive updates about the public hearing please email PCPCH@OHA.oregon.gov.

By March 30, 2024, the program will publish the PCPCH 2024 Recognition Criteria Technical Specifications and Reporting Guide (i.e., technical assistance or TA Guide). (Here is a link to the current 2020 TA Guide) This document details the technical specifications and requirements for every measure.

By October 2024, practices will begin applying under the revised PCPCH Standards. All practices applying or re-applying after October 2024 must meet the revised standards. Practices that apply under the 2020 PCPCH Standards during the 2024 calendar year will be required to re-apply under the 2024 PCPCH Standards within 12 months.

Additional Information

OHA Patient-Centered Primary Care Home Program website:
www.PrimaryCareHome.Oregon.gov

- Information on PCPCH Standards Advisory Committee
- PCPCH Program Health Equity Initiative report **(community listening sessions)**
- Evaluation of Oregon's Patient Centered Primary Care Homes on Expenditures and Utilization from 2011 to 2019

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Proposed Recognition Criteria Revisions for Patient Centered Primary Care Homes

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*				
Standard 1.A) ~~In-Person Access~~ Timely Access and Communication				
1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams.	**Unchanged**	No	5	**No**
1.A.2 PCPCH regularly tracks timely access and communication to clinical staff and care teams, and **either meets specific targets or** has implemented an improvement plan to improve ~~their~~ outcomes.	**Revised**	No	10	**No**
Standard 1.B) After Hours Access				
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	**Unchanged**	No	5	**Yes**
Standard 1.C) Telephone ~~and Electronic~~ Access				
1.C.0 PCPCH ~~provides~~ **assures that its patients have** continuous access to clinical advice by telephone.	**Revised**	Yes	0	**No**
1.C.1 PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.	**New**	**No**	**5**	**Yes**
Standard 1.D) Same Day Access				
1.D.1 PCPCH ~~provides~~ **offers** same day appointments.	**Revised**	No	5	**No**
Standard 1.E) Electronic Access (~~*Progressive*~~ *Check all that apply*)				
~~1.G.1~~ 1.E.1 PCPCH regularly communicates with patients through a patient portal.	**Revised**	No	5	**No**
~~1.E.1~~ 1.E.2 –PCPCH provides patients with access to an electronic copy of their health information **in an accessible format.**	**Revised**	No	~~5~~ **10**	**Yes**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 1.F) Prescription Refills				
1.F.2 PCPCH tracks the time to completion for prescription refills.	**Unchanged**	No	10	**No**
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	**Unchanged**	No	15	**No**
Standard 1.G) Alternative Access *(Check all that apply)*				
1.G.1 ~~PCPCH regularly communicates with patients through a patient portal.~~ **PCPCH offers telehealth services to its patients in their primary language.**	**New**	**No**	**5**	**Yes**
1.G.2 ~~PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.~~ **PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.**	**Revised**	No	10	**Yes**
1.G.3 PCPCH regularly provides patient care in community-based settings.	**New**	**No**	**15**	**Yes**
CORE ATTRIBUTE 2: ACCOUNTABILITY - ***"Take responsibility for making sure we receive the best possible health care."***				
Standard 2.A) Performance and ~~&~~ Clinical Quality *(Check all that apply)*				
2.A.0 PCPCH tracks and reports to ~~the~~ OHA three ~~measures from the set of PCPCH Quality Measures~~ **primary care quality measures.**	**Revised**	Yes	0	**No**
~~**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.~~	**Deleted**	~~No~~	~~5~~	**No**
2.A.1 PCPCH tracks and reports to OHA disparities in three primary care quality measures.	**New**	**No**	**5**	**No**
2.A.2 PCPCH tracks, reports to ~~the~~ OHA, and demonstrates a combination of improvement and meeting benchmarks on ~~of the PCPCH Quality measures~~ **three primary care quality measures.**	**Revised**	No	10	**No**
2.A.3 PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.	**New**	**No**	**15**	**Yes**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 2.B) ~~Public Reporting~~ Value-Based Payment				
~~**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.~~	**Deleted**	~~No~~	~~5~~	**No**
2.B.1 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with one payer.	**New**	**No**	**5**	**No**
2.B.2 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	**New**	**No**	**10**	**No**
2.B.3 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 3A or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	**New**	**No**	**15**	**No**
Standard 2.C) Patient and Family Involvement in Quality Improvement				
2.C.1 PCPCH involves patients, families, and caregivers as advisors on at least one quality or safety initiative per year.	**Unchanged**	No	5	**No**
2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development ~~and/~~or educational improvement activities.	**Revised**	No	10	**Yes**
2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	**Unchanged**	No	15	**No**
Standard 2.D) Quality Improvement				
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.	**Unchanged**	No	5	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
2.D.2 PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	**Unchanged**	No	10	**No**
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	**Unchanged**	No	15	**No**
Standard 2.E) ~~Ambulatory Sensitive Utilization~~ Ambulatory Care Sensitive Conditions Utilization *(Check all that apply)*				
~~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.~~	**Deleted**	~~No~~	~~5~~	**No**
2.E.2 PCPCH identifies patients **experiencing** ~~with~~ unplanned or adverse patterns ~~for~~ **in** at least one ~~selected~~ utilization measure and contacts patients, families or caregivers for follow-up care. ~~if needed, within an appropriate period of time.~~	**Revised**	No	10	**No**
~~2.E.3~~ ~~PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure.~~	**Deleted**	~~No~~	~~15~~	**No**
2.E.3 PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families or caregivers for follow-up care.	**New**	**No**	**15**	**Yes**
Standard 2.F) PCPCH Staff Vitality				
2.F.1 PCPCH ~~uses a structured process to identify opportunities~~ **develops and implements a strategy** to improve the vitality of its staff.	**Revised**	No	5	**No**
2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	**Unchanged**	No	10	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - *"Provide or help us get the health care, information, and services we need."*				
Standard 3.A) Preventive Services				
3.A.1 PCPCH routinely offers or coordinates recommended **age and gender appropriate** preventive services ~~appropriate~~ for its **patient** population ~~(i.e. age and gender)~~ based on best available evidence, and identifies areas for improvement.	**Revised**	No	5	**No**
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services and has an improvement strategy in effect to address gaps in preventive service offerings as appropriate for ~~the~~ **its** patient population.	**Revised**	No	10	**No**
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	**Unchanged**	No	15	**No**
Standard 3.B) 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.	**Revised**	Yes	0	**No**
Standard 3.C) Behavioral Health Services *(Check all that apply)*				
3.C.0 PCPCH has a ~~screening strategy~~ **routine assessment** ~~for~~ **to identify patients with** mental health, substance use, and developmental conditions, ~~documents on-site and local referral resources and processes.~~ **and coordinates their care.**	**Revised**	Yes	0	**No**
~~**3.C.1**~~ **3.C.2.a** PCPCH collaborates ~~and coordinates care~~ or is co-located, **and coordinates care,** with specialty mental health, substance use disorder, and developmental providers. ~~PCPCH also provides co-management based on its patient population needs.~~	**Revised**	No	~~5~~ **10**	**No**
~~**3.C.2**~~ **3.C.2.b** PCPCH provides ~~onsite~~ pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	**Revised**	No	10	**No**
3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	**Unchanged**	No	15	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 3.D) ~~Comprehensive Health Assessment & Intervention~~ Health-Related Social Needs (~~*Progressive*~~ *Check all that apply*)				
~~3.D.1~~ ~~PCPCH has a routine assessment to identify health-related social needs in its patient population.~~	**Deleted**	~~No~~	~~5~~	**No**
3.D.2 ~~PCPCH tracks referrals to community-based agencies for patients with health-related social needs.~~ **PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.**	**Revised**	No	10	**Yes**
3.D.3 ~~PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs.~~ **PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.**	**Revised**	No	15	**Yes**
Standard 3.E) Preventive Services Reminders				
3.E.1 PCPCH generates lists of patients who need reminders for preventive services and ensures that they are sent appropriate reminders.	**New**	**No**	**5**	**No**
3.E.2 ~~PCPCH 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.~~ **PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services.**	**Revised**	No	10	**No**
~~3.E.3~~ ~~PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also 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.~~	**Deleted**	~~No~~	~~15~~	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
3.E.3 PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach strategy.	**New**	**No**	**15**	**Yes**
Standard 3.F) Oral Health Services				
3.F.1 PCPCH ~~utilizes a screening and/or assessment strategy~~ **screens or assesses its patients** for oral health needs.	**Revised**	No	5	**No**
3.F.2 PCPCH ~~utilizes a screening and/or assessment strategy~~ **screens or assesses its patients** for oral health needs and provides age-appropriate interventions.	**Revised**	No	10	**No**
3.F.3 PCPCH provides oral health services by dental providers.	**Unchanged**	No	15	**No**
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*				
Standard 4.A) ~~Personal Clinician Assigned~~ Personal Clinician Assignment and Continuity				
4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team **and has a process for considering patient choice in assignment. PCPCH also reports the percent of visits in which a patient saw their assigned clinician or team.**	**Revised**	**Yes**	0	**No**
~~4.B.2~~ 4.A.2 PCPCH tracks and improves the percent of ~~patient~~ visits ~~with~~ **in which a patient saw their** assigned clinician or team.	**New**	**No**	**10**	**No**
~~4.A.3 PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team.~~	**Deleted**	**~~No~~**	**~~15~~**	**No**
~~4.B.3~~ 4.A.3 PCPCH meets a benchmark ~~in~~ **for** the percent of ~~patient~~ visits ~~with~~ **in which a patient saw their** assigned clinician or team**.**	**Revised**	No	15	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
~~Standard 4.B) Personal Clinician Continuity~~				
4.B.0 ~~PCPCH reports the percent of patient visits with assigned clinician or team. (D)~~	**Deleted**	~~Yes~~	~~0~~	**No**
4.B.2 ~~PCPCH tracks and improves the percent of patient visits with assigned clinician or team.~~	**Deleted**	~~No~~	~~10~~	**No**
4.B.3 ~~PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.~~	**Deleted**	~~No~~	~~15~~	**No**
Standard ~~4.G~~ 4.B) Medication Reconciliation and Management (~~*Progressive*~~ *Check all that apply*)				
~~4.G.2~~ 4.B.2 PCPCH **provides ~~has a process for~~** medication reconciliation **and medication management for** its patients. ~~with complex or high-risk medication concerns~~	**Revised**	No	10	**No**
~~4.G.3~~ 4.B.3 PCPCH provides medication management for **its** patients **by a pharmacist.** ~~with complex or high-risk medication concerns.~~	**Revised**	No	15	**No**
Standard 4.C) Organization of Clinical Information				
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the ~~Centers for Medicare and Medicaid Services~~ **Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program** and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.	**Revised**	Yes	0	**No**
4.C.1 PCPCH documents its patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record.	**New**	**No**	**5**	**No**
4.C.2 PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.	**New**	**No**	**10**	**Yes**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 4.D) Clinical Information Exchange				
4.D.2 PCPCH exchanges clinical information electronically ~~to~~ **with** another provider or setting of care.	**Revised**	No	10	**No**
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities ~~(electronic health information exchange)~~ **through an electronic health information exchange.**	**Revised**	No	15	**No**
Standard 4.E) ~~Specialized Care~~ Hospital Setting Transitions				
4.E.0 PCPCH has a ~~written agreement~~ **documented process for transitions of care** with its usual hospital providers or directly provides routine hospital care.	**Revised**	Yes	0	**No**
4.E.2 PCPCH has a process for following up with its patients post-discharge from the hospital and emergency department.	**New**	**No**	**10**	**No**
Standard 4.F) Planning for Continuity				
~~**4.F.1**~~ **4.F.0** PCPCH **has a process for reassigning** ~~demonstrates a mechanism to reassign~~ administrative requests, prescription refills, and clinical questions when a provider is not available.	**Revised**	~~No~~ **Yes**	~~5~~ **0**	**No**
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*				
Standard 5.A) Population Data Management (~~*Check all that apply*~~ *Progressive*)				
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.~~ **PCPCH uses data on its entire patient population to track overall health needs or engage in proactive patient population management.**	**Revised**	No	5	**No**
5.A.2 PCPCH ~~demonstrates the ability to stratify~~ **stratifies** its entire patient population according to health risk. ~~such as special health care needs or health behavior.~~	**Revised**	No	10	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
5.A.3 PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category.	**New**	**No**	**15**	**Yes**
Standard 5.B) Health Care Cost Navigation *(Check all that apply)*				
5.B.1 PCPCH informs its patients of preventive services that do not require cost-sharing.	**New**	**No**	**5**	**No**
5.B.3 PCPCH assists its patients in navigating the cost and payment options for their care.	**New**	**No**	**15**	**Yes**
Standard 5.C) Complex Care Coordination *(Check all that apply)*				
5.C.1 ~~PCPCH 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~~. **PCPCH assigns care coordination responsibilities to specific practice staff and informs patients, families, and caregivers on how to access care coordination services.**	**Revised**	No	5	**No**
5.C.2 PCPCH ~~describes and demonstrates its process for identifying and coordinating the care of diverse~~ **identifies** patients with complex care needs **and coordinates their care.**	**Revised**	No	10	**No**
5.C.3 PCPCH collaborates with ~~diverse~~ patients, families, or caregivers to develop individualized **and culturally appropriate** written care plans for complex medical or social concerns.	**Revised**	No	15	**No**
Standard 5.D) Test and Result Tracking				
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely, confidential notification and explanation of results to patients, family, or caregivers as well as to ordering clinicians.	**Unchanged**	No	5	**No**
Standard 5.E) Referral and ~~& Specialty~~ Care Coordination with Specialists, Care Facilities, and Governmental Systems *(Check all that apply)*				
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians.	**Unchanged**	No	5	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
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).~~ **PCPCH coordinates care when its patients receive care in specialized settings such as hospitals, skilled nursing or other long-term care facilities, and in-patient behavioral health facilities.**	**Revised**	No	10	**No**
5.E.3 ~~PCPCH 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.~~ **PCPCH coordinates care for its patients who are engaged with or receiving services from the Oregon Department of Human Services, criminal justice, education or public health systems.**	**Revised**	No	15	**No**
Standard 5.F) End of Life Planning				
5.F.0 PCPCH ~~demonstrates~~ **has** a process ~~to~~ **for** ~~offer or coordinate~~ **offering or coordinating** hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	**Revised**	Yes	0	**No**
5.F.1 PCPCH has a process **for engaging** ~~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.~~	**Revised**	No	5	**No**
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - *"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."*				
Standard 6.A) Meeting Language and ~~&~~ ~~Cultural~~ Health Literacy Needs (~~*Progressive*~~ *Check all that apply*)				
6.A.0 PCPCH offers time-of-service ~~translation~~ **interpretation** to communicate with patients, families, or caregivers in their ~~language of choice~~ **primary language**.	**Revised**	Yes	0	**No**
6.A.1 PCPCH provides written patient materials in **languages other than English.** ~~non-English languages spoken by populations served at the clinic.~~	**Revised**	No	5	**Yes**
6.A.2 PCPCH assures that patient communications and materials are at an appropriate health literacy level.	**New**	No	10	**Yes**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 6.B) Education and ~~&~~ Self-Management Support				
6.B.1 PCPCH provides **culturally and linguistically appropriate** patient-specific education resources to **its** ~~their~~ patient population.	**Revised**	No	5	**No**
6.B.2 PCPCH provides **culturally and linguistically appropriate** patient-specific education resources and offers **or connects patients, families, and caregivers with** self-management support resources. ~~to their patient population.~~	**Revised**	No	10	**Yes**
Standard 6.C) Experience of Care				
6.C.0 PCPCH surveys a sample of its population on their experience**s with specific areas** of care **and shares results with clinic staff.** ~~The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness.~~ **PCPCH also meets a survey completion benchmark or has a strategy to increase the number of surveys completed.**	**Revised**	Yes	0	**No**
6.C.1 PCPCH surveys a sample of its population on their experience**s with specific areas** of care **and demonstrates the utilization of survey data in quality improvement activities.** ~~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.~~	**Revised**	No	5	**No**
6.C.2 PCPCH surveys a sample of its population on their experience**s with specific areas** of care, **including health equity, and demonstrates the utilization of survey data in quality improvement activities.** ~~using of one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).~~	**Revised**	No	10	**Yes**
~~**6.C.3** PCPCH surveys a sample of its population on their experience of care using of 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).~~	**Deleted**	~~No~~	~~15~~	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 6.D) Communication of Rights, Roles, and Responsibilities				
~~**6.D.1**~~ **6.D.0** 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.	**Revised**	~~No~~ **Yes**	~~5~~ **0**	**No**
Standard 6.E) Cultural Responsiveness of Workforce				
6.E.0 PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.	**New**	**Yes**	**0**	**No**
6.E.3 PCPCH partners with one or more traditional health workers or traditional health worker services.	**New**	**No**	**15**	**Yes**