# PCPCH Measure Implementation Examples

The Patient-Centered Primary Care Home (PCPCH) Program published Version 4 of the 2025 PCPCH Technical Assistance Guide (TA Guide) in November of 2026, which summarized and condensed the specifications for each PCPCH standard and measure to reduce the amount of required reading for clinics participating in the program.

The following document includes some of the extra language that was present in the prior, longer version of the TA Guide. Many of these examples, clarifications, and all other important information are still included in the updated version of the TA Guide (see link above). This is intended only as a supplementary resource for clinics looking for extra clarification or ideas on what would, or would not, meet specific PCPCH measures.

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

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# Standard 1.A – Timely Access and Communication

## Measure 1.A.1

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

***Activities that do not meet 1.A.1:***

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

## Measure 1.A.2

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

***Activities that do not meet 1.A.2:***

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

# Standard 1.B – After-Hours Access

## Measure 1.B.1

***Activities that do not meet 1.B.1:***

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

# Standard 1.C – Telephone Access

## Measure 1.C.0

**Examples:**

- A live person at the clinic answers business and after-hours phone calls and refers patients to a nurse or clinician for clinical advice, as appropriate.
- An on-call provider or nurse answers business and after-hours phone calls and records the encounter in the phone notes.
- The clinic has a live answering service that triages appropriate business and after-hours phone calls to an on-call clinician.
- The clinic contracts with a 24/7 nurse advice line. The nurse advice line sends faxes to the clinic with information about patient calls that came in the night before and inputs this information into patients' medical records.
- A small rural clinic develops an innovative way to ensure patients have 24/7 access to clinical advice. It organizes an on-call pool of providers from other clinics in the county, and they all share call rotation. The providers do not have a common EHR so instead use a paper-based process to document their after-hours calls. Providers fax or scan/email individual clinics their after-hours notes within 24 hours of the call.

***Activities that do not meet 1.C.0:***

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

## Measure 1.C.1

**Examples:**

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

***Activities that do not meet 1.C.1:***

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

# Standard 1.D – Same-Day Access

## Measure 1.D.1

**Examples:**

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

***Activities that do not meet 1.D.1:***

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

# Standard 1.E – Electronic Access

## Measure 1.E.1

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

***Activities that do not meet 1.E.1:***

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

## Measure 1.E.2

**Examples:**

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

***Activities that do not meet 1.E.2:***

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

# Standard 1.F – Prescription Refills

## Measure 1.F.2

**Examples:**

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

***Activity that does not meet 1.F.2:*** The clinic generates a report on refill completion times only once per year rather than tracking it on a more regular basis.

## Measure 1.F.3

**Examples:**

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

***Activity that does not meet 1.F.3:*** The clinic is tracking prescription refill completion times but is not meeting the 90% benchmark or haven't demonstrated minimum improvement over the last 6 or 12 months.

# Standard 1.G - Alternative Access

## Measure 1.G.1

**Examples:**

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

***Activities that do not meet 1.G.1:***

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

## Measure 1.G.2

**Examples:**

- A clinic offers its patients mobile van visits offsite every other Monday. These mobile appointment slots are typically filled, and patient feedback suggests that they are improving care for elderly patients, those with disabilities, and those located farther from the clinic address.
- A clinic starts a diabetes education group class for its patients once per month, in the evening, that is facilitated by a Nutritionist. Following the class, a physician offers one-on-one medical decision-making for each group participant. Survey results indicate that these classes are improving access to care for these patients.
- After receiving feedback from a patient-family advisory council, a clinic finds that home or SNF visits best meet the needs of their patient population. They have two providers that offer in-home or SNF visits on a regular basis. Appointments are listed as such on the schedule or in the chart; "Alternative Visit Type", or "Home/SNF visit."

***Activities that do not meet 1.G.2:***

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

## Measure 1.G.3

**Examples:**

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

***Activities that do not meet 1.G.3:***

- A clinic offers care in an alternative community setting but only to its registered patients.

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

# Standard 2.A – Performance and Clinical Quality

## Measure 2.A.0

***Activities that do not meet 2.A.0***

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

## Measure 2.A.1

**Examples:**

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

***Activities that do not meet 2.A.1:***

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

## Measure 2.A.2

***Activities that do not meet 2.A.2:***

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

## Measure 2.A.3

**Examples:**

- A clinic is tracking three primary care quality measures: "Diabetes: Hba1c poor control," "Colorectal Cancer screening," and "Breast Cancer screening." It identifies in its performance data that a couple patient subgroups are being screened less for cancer and experiencing higher (HbA1c) levels than their average patient with diabetes. They decide to focus on one of these subgroups: their Latino/a patients. They are able to demonstrate that, over the past year, they closed the gap between their Latino/a patients and the rest of their patient population by 1% in colorectal cancer screenings, 0.5% in breast cancer screenings, and 3% in Hba1c poor control.
- A solo clinic is tracking three primary care quality measures: "Depression screening," "Oral evaluation for adults with diabetes," and "Cervical Cancer screening." It has identified that its rural patients are being screened less for depression and oral health than its non-rural patients. It has also discovered that its patients who identify as LGBTQIA2S+ are being screened less for cervical cancer. The clinic takes steps to reduce barriers to care for its rural patients and LGBTQIA2S+ patients and is able to demonstrate better screening rates among these groups over the past 6 months.

***Activities that do not meet 2.A.3:***

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

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

### Measure 2.C.1

**Examples:**

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

***Activities that do not meet 2.C.1:***

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

### Measure 2.C.2

**Examples:**

- To help enhance their patients' experience, a clinic maintains a diverse patient, family, and caregiver advisory council (PFAC) that reviews clinic data and quality improvement efforts on a quarterly basis to provide advice and guidance.
- A clinic forms an ongoing quality improvement committee made up of its own patients, patient family members, and caregivers spanning a variety of ages and medical conditions. This team brainstorms solutions to challenges patients face in using the patient portal, which they monitor and evaluate over the course of a year to make the portal more accessible for all.
- A health system with multiple clinics has a joint patient and family advisory council for three of their rural clinics that are close in distance, have similar patient populations, and share similar circumstances and challenges (such as a lack of local resources). The advisory council includes at least three patients from each location to represent their clinic. Because of the similarities between the clinics, they sometimes develop quality improvement initiatives that are launched at all three locations, but also work hard to develop improvement activities that are tailored to a specific location when prompted by feedback from its respective patients.
- 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 not only gathered valuable feedback but helped parents learn how to navigate the complex health system together, ensure that their children received the care that they needed, and provide emotional support to one another.

***Activities that do not meet 2.C.2:***

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

### Measure 2.C.3

**Examples:**

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

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

## Standard 2.D – Quality Improvement

### Measure 2.D.1

**Examples:**

- A clinic is looking to improve A1C scores and does a Plan Do Study Act (PDSA) cycle on expanding lab hours to provide more time for A1C testing. The clinic documents the different PDSA steps to guide their ongoing project decisions.
- A clinic wants to decrease the number of patients that have a high blood pressure reading at the time of their appointment. They decide to use SMARTIE goals (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable) as a framework.

They implement a process to complete a second blood pressure check after patients have had some time to get settled into their appointment. The clinic documents each specific action it takes towards its SMARTIE goals as it implements new processes for medical assistants and providers who help track patients' blood pressure.

***Activity that does not meet 2.D.1:*** The clinic implements an improvement project but cannot produce examples of the performance data it used and the actions it took to improve on a clinical process.

## Measure 2.D.2

**Examples:**

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

***Activity that does not meet 2.D.2:*** Staff member(s) from the clinic participate on a QI committee at an organizational or health system-wide level, but they do not define quality improvement initiatives specific to their clinic or their patient population.

## Measure 2.D.3

**Examples:**

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

***Activities that do not meet 2.D.3:***

- A clinic can demonstrate multiple past QI projects but no standardized monitoring or evaluation methodology and/or demonstration of how the projects support the overall annual strategic QI goals.

- A clinic tracks and reports on performance metrics but does not have an annual improvement strategy to identify areas of focus, annual goals and evidence of structured improvement projects.
- A clinic has an annual strategic plan with goals and methods based solely on incentive metrics that are prioritized by a CCO or payer (does not include clinic-specific goals).
- A clinic has an annual strategic plan that only accounts for CCO patients or another population subset and is not relevant to the clinic's entire patient population.

## Standard 2.E – Ambulatory Care Sensitive Conditions Utilization

### Measure 2.E.2

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

***Activities that do not meet 2.E.2***

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

### Measure 2.E.3

**Examples:**

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

various resources into its existing patient follow-up calls/interventions including transportation options under OHP or local agencies, and information about mammogram mobile van locations.

***Activity that does not meet 2.E.3:*** A clinic is tracking at least one ACSC utilization measure but is not able to segment its performance data to identify patient subgroups experiencing disparities.

# Standard 2.F – PCPCH Staff Vitality

## Measure 2.F.1

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

***Activities that do not meet 2.F.1:***

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

## Measure 2.F.2

**Examples:**

- A wellness committee develops an anonymous comment box process that employees can use to submit feedback on how their new referral workflows affect their roles. After reviewing the feedback at an all-staff meeting, the clinic makes a few changes in the workflow, and after three months asks for more anonymous feedback from the staff to see if these changes have affected the team's morale.
- A clinic conducts focus groups within each of its departments to discuss how the physical environment, due to new construction, could be more conductive to employees' well-being. It summarizes feedback at an all-staff meeting and generates ideas from staff about how to address concerns. Within seven months, it initiates changes that improve care team dynamics, and coordinates another round of focus groups. Overall sentiments reflect how much more satisfied employees are with the new office space.
- Questionnaire assessments are distributed annually to evaluate how employees are adapting to systemic changes and gather suggestions they might have, including how

new technology could be utilized. The clinic's leadership seeks employee feedback to intentionally improve or maintain staff vitality.
- A clinic uses monitoring and evaluation methods to assess staff vitality activities, such as Plan-Do-Study-Act (PDSA) and Specific-Measurable-Achievable-Realistic-Timely (SMART) goals.

***Activity that does not meet 2.F.2:*** A clinic takes action to address staff vitality without evaluating the success of those actions. For example, after receiving feedback from a staff survey that frustrations were high (on a scale of 1-10), a clinic implements new workflows to streamline how they coordinate case management for patients. However, the clinic does not follow-up and measure the difference that the new workflows made. Therefore, despite having a sense that case management is working better for staff and patients, the clinic has not measured the actual impact on staff vitality.

# Standard 3.A – Preventive Services

## Measure 3.A.1

**Examples:**
- A health care team member or dedicated care coordinator is responsible for the provision and coordination of preventive services for the clinic's patient population, which include screening questions, appointments, procedures, test/labs, and scrubbing patient records the day before an appointment to identify patients in need of preventive services.
- A clinic has multiple workflows ahead of, and during, patient visits to help close gaps in their care. For example the front desk hands out any missing screeners in the waiting area, MAs scrub patient charts during visits and offer patients any missing vaccines that they are due for, and providers offer to include any recommended screenings or preventive services in today's appointment, or assist patients in scheduling those services.

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

## Measure 3.A.2

**Examples:**
- A clinic tracks which patients are due for a colonoscopy, the number of patients that completed colonoscopy, identifies care gaps to ensure patients due for colonoscopy are scheduled and complete the service, and enters the screening results in the patient's

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

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

### Measure 3.A.3

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

***Activity that does not meet 3.A.3:*** A clinic offers many preventive services but does not consistently offer or coordinate 90% of the preventive services in the table below that are appropriate for their population (see calculation instructions).

## Standard 3.B – Medical Services

### Measure 3.B.0

***Activity that does not meet 3.B.0:*** The clinic only provides some of the categories of care listed.

## Standard 3.C – Behavioral Health Services

### Measure 3.C.0

***Activities that do not meet 3.C.0:***
- A clinic provides new patient intake forms with questions about mental health and substance use, but there is no other defined, routine screening strategy for these issues beyond the new patient appointment.
- Screening takes place only at provider discretion or based upon diagnosis.
- A clinic only screens one age group or type of demographic instead of screening all its patients, as appropriate.
- A clinic screens patients for behavioral health conditions but does not have a defined strategy to respond to positive screens or refer patients to external providers when needed.

## Measure 3.C.2.a

**Examples:**

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

***Activity that does not meet 3.C.2.a:*** A clinic makes referrals to, or is co-located with, behavioral health providers but does not engage in ongoing two-way communication, collaboration, or coordination as a part of the patient's care.

## Measure 3.C.2.b

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

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

## Measure 3.C.3

***Activities that do not meet 3.C.3:***

- A behavioral health provider is available, but the clinic does not meet the full criteria for integrated behavioral health services described in the specifications section of measure 3.C.3.

- Behavioral and physical health providers practice in the same location, but they do not have meaningful communication with one another or coordinate patient care.
- For patients that require referrals to external behavioral health providers, the clinic faxes chart notes between the clinic and external behavioral health providers but there is no evidence in the medical record of two-way communication between clinicians and specialty providers regarding co-management of patients' plan of care.

# Standard 3.D – Health-Related Social Needs

## Measure 3.D.2

***Activity that does not meet 3.D.2:*** Providers assess the health-related social needs of their patients on an ad-hoc basis. The assessment is not routine, systematic, or given to their entire patient population.

## Measure 3.D.3

**Examples:**

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

provider can request "flexible services" from the patients' CCO. For example, the request may include funds or services for food supports, such as grocery delivery, food vouchers, or medically tailored meals.[1]

***Activities that do not meet 3.D.3:***

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

# Standard 3.E – Preventive Service Reminders

## Measure 3.E.1

**Examples:**

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

***Activities that do not meet 3.E.1:***

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

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

## Measure 3.E.2

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

***Activity that does not meet 3.E.2:*** A clinic reminds its patients of upcoming preventive services that are due, but it does not track if the recommended preventive services have been completed.

## Measure 3.E.3

**Examples:**

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

***Activities that do not meet 3.E.3:***

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

# Standard 3.F – Oral Health Services

## Measure 3.F.2

**Examples:**

- A clinic assesses its diabetic patients with substance use disorder for oral health needs and engages in active relationships with dental providers to ensure increased access to oral health for these patients by coordinating care and sharing records in a more streamlined manner.

- A family practice screens its pediatric 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 pediatric patients.
- A clinic assesses all its patients for oral health needs and provides immunocompromised patients with guidance on accessing oral health services and follows up with patients regarding impact and barriers.

***Activities that do not meet 3.F.2:***

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

## Measure 3.F.3

**Example:** A clinic has integrated oral health services which are available to all its pediatric 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, pediatric patients are referred to the co-located dental clinic via a shared EHR system. By having the same front desk check-in for primary care and oral health appointments, the clinic proactively provides opportunities for these patients to receive oral health evaluations, diagnoses, prevention and/or treatment of oral health diseases, disorders, and/or conditions.

***Activities that do not meet 3.F.3:***

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

# Standard 4.A – Personal Clinician Assignment and Continuity

## Measure 4.A.0

***Activities that do not meet 4.A.0:***

- There is no clinic-wide strategy in place to assign patients to clinicians or a team; assignment happens on an ad-hoc basis.
- There is no process for incorporating patient choice, need, or background into clinician assignment.

- A clinic calculates its data based on all of its primary care providers being on one "team" but does not inform their patients that they operate under a team-based model and what this means for their care.

## Measure 4.A.2

***Activities that do not meet 4.A.2:***

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

## Measure 4.A.3

***Activities that do not meet 4.A.3:***

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

# Standard 4.B – Medication Reconciliation and Management

## Measure 4.B.2

**Examples:**

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

***Activities that do not meet 4.B.2:***

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

## Measure 4.B.3

**Examples:**

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

***Activities that do not meet 4.B.3:***

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

# Standard 4.C – Organization of Clinical Information

## Measure 4.C.0

***Activities that do not meet 4.C.0:***

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

## Measure 4.C.1

**Examples:**

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

***Activity that does not meet 4.C.1:*** A clinic has a section in their EHR designated for one or more of the patient characteristics described above, but does not have a process for regularly collecting or obtaining this information.

## Measure 4.C.2

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

***Activity that does not meet 4.C.2:*** A clinic excludes all of their "unknowns" from their denominator. Clinics may exclude patients who intentionally prefer not to provide information for a particular category, but may not exclude other patients for which their status is unknown.

# Standard 4.D – Clinical Information Exchange

## Measure 4.D.2

**Examples:**

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

***Activities that do not meet 4.D.2:***

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

## Measure 4.D.3

**Examples:**

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

***Activities that do not meet 4.D.3:***

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

# Standard 4.E – Hospital Setting Transitions

## Measure 4.E.0

**Examples:**

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

## Measure 4.E.2

**Examples:**

- As per their documented policy, a clinic devotes medical assistant staff time to conducting hospital follow-up calls with their patients and families within 3 days of a hospital discharge to schedule for follow-up with the patient's primary care provider and assess needs such help coordinating with other medical providers or procedures.
- A clinic's care manager nursing team is alerted by the hospital discharge planning team of an upcoming discharge to a skilled nursing facility to plan for the patient's needs including a follow-up appointment at the clinic, and to update the clinic's medical record with information regarding the transfer.
- A clinic has its clinical pharmacist outreach to its patients that were recently discharged from another facility such as a hospital or skilled nursing facility to review their medications to ensure the clinic has an up-to-date medication list, has reconciled any changes in medication or dosages, and that the patient is taking them correctly and safely. The pharmacist also checks to make sure there is a follow-up visit scheduled with the patient's primary care provider and transfers the telephone call to the front desk for scheduling.
- A pediatric clinic receives a notification that three of its patients were seen in the ED the night before. The patients' care teams are notified as per the clinic's discharge workflow policy. They review the discharge notes in the electronic health system (or by requesting them from the hospital if not connected to the same system) and determine the need for a call to the family and/or to schedule a follow-up visit within the week.

***Activity that does not meet 4.E.2:*** A clinic has a policy, protocol or workflow for transitions of care with its hospital providers but does not have a process for following up directly with patients or families after they are discharged.

# Standard 4.F – Planning for Continuity

## Measure 4.F.0

**Examples:**

- Urgent patient requests are automatically routed to a covering provider when their team members are unavailable, and patients are notified if a non-urgent request won't be completed within a specified time frame.
- On-call providers are responsible for patient requests when team members are not available, and there is always a designated on-call provider available with interpreter services as needed.
- A team of medical assistants are responsible for in-basket coverage (i.e., daily work tasks) and know who is responsible for monitoring, in case of an absence.
- Locum providers are available to return phone calls regarding clinical questions from patients to their PCP.

***Activities that do not meet 4.F.0:***

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

# Standard 5.A – Population Data Management

## Measure 5.A.1

**Examples:**

- A clinic maintains an active searchable registry of patients with a specific condition (e.g., diabetes, pregnancy). Registries can sometimes be integrated in the EHR, but clinics can also use a simple tracking system, such as Microsoft Excel.
- A clinic uses a list of patients to generate patient reminder outreach for indicated care (e.g., lab tests, imaging, well-child appointments, immunizations).
- A clinic maintains a registry of patients with diabetes or asthma and tracks the percentage of patients that are up to date on indicated care and testing (e.g., hemoglobin A1c, consistently taking appropriate medications).

- A clinic keeps a registry of pregnant patients and follows up with those who miss appointments for prenatal care.
- A clinic generates an inclusive list of patients in the clinic who have a particular health behavior to target health promotion activities (e.g., smoking, obesity, hypertension, uncontrolled diabetes) or need for follow-up.

***Activities that do not meet 5.A.1:***

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

## Measure 5.A.2

**Examples:**

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

***Activities that do not meet 5.A.2:***

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

## Measure 5.A.3

**Examples:**

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

***Activities that do not meet 5.A.3:***

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

# Standard 5.B – Health Care Cost Navigation

## Measure 5.B.1

**Examples:**

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

***Activities that do not meet 5.B.1:***

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

## Measure 5.B.3

***Activities that do not meet 5.B.3:***

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

# Standard 5.C – Complex Care Coordination

## Measure 5.C.1

***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.

## Measure 5.C.2

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

***Activity that does not meet 5.C.2:*** A clinic identifies opportunities for complex care coordination on a case-by-case basis, based on provider discretion or an unofficial/undocumented process.

## Measure 5.C.3

**Example:** A pediatric clinic collaborates with its identified complex patients and their parents/caretakers to create personal and unique care plans for them. This becomes an essential focal point in their charts and is incorporated in their EHR system. The care plan is managed by the medical home but is informed by the guidance counselors at the local

elementary schools or anyone else involved in the care of the child. Each care plan includes patient-specific short-term and long-term health goals, and the action plan for achieving them. The clinic also decides to include in each care plan patient-specific education regarding conditions and treatments, self-management tools for chronic conditions, and the names and roles of community-based support outside the clinic. The entire and continual care plan process includes:

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

***Activities that do not meet 5.C.3***

- A clinic copy-pastes the provider's general assessment from a patient's chart notes into their After-Visit Summary in place of creating an individualized patient care plan.
- A clinic develops care plans but does not include patients' short-term and long-term health goals or the action plan for achieving them.
- A clinic develops a care plan for each patient instead of collaborating with the patient and/or family or caregivers to develop personal goals.

# Standard 5.D – Test and Result Tracking

## Measure 5.D.1

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

***Activities that do not meet 5.D.1:***

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

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

### Measure 5.E.1

**Examples:**

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

***Activities that do not meet 5.E.1:***

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

### Measure 5.E.2

**Examples:**

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

***Activities that do not meet 5.E.2:***

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

## Measure 5.E.3

**Examples:**

- A pediatric clinic works to ensure consistent primary care for its patients in the foster care system by coordinating with their caseworkers or DHS, resource (foster) parents, and/or patients themselves as they experience changes in housing placements. The clinic also works to facilitate the transition out of pediatric care for teens aging out of the foster care system by connecting and/or establishing them with family care practices in their area.
- A clinic collaborates with local schools on patient IEPs, or collaborates with the parents of patients with IEPs to better coordinate their care.
- A clinic provides care coordination services to formerly-incarcerated individuals or those transitioning out of the criminal justice system.[2]

***Activities that do not meet 5.E.3:***

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

# Standard 5.F – End of Life Planning

## Measure 5.F.0

**Examples:**

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

***Activity that does not meet 5.F.0:*** The clinic has a list of hospice or palliative providers/ facilities but cannot provide examples of patient referrals or a policy or protocol for offering these services.

## Measure 5.F.1

**Examples:**

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

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

- A clinic develops advanced care plans with its patients and caregiver(s) that detail patients' end of life treatment wishes and consider their primary language and cultural preferences.
- A pediatric practice has a process for engaging in end-of-life planning and counseling for its patients and their families in the rare cases when this is required. This includes counseling or other supportive services for siblings.

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

# Standard 6.A – Meeting Language and Health Literacy Needs

## Measure 6.A.0

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

***Activities that do not meet 6.A.0:***
- A clinic has multilingual providers available for the most common languages spoken among its patient population (e.g., Spanish), but no plan or process for how to provide interpretation services in the event that a patient speaks a different primary language.
- A clinic routinely relies on the family members of non-English speaking patients to act as interpreters without first offering them free clinic interpretation services.
- A clinic uses google translate.
- Interpreter services, providers, or other employees acting as interpreters are only available at certain times during clinic business hours, but not available at other times and the clinic does not have a strategy to provide alternative options for interpreter services during the times when they are unavailable, or cannot offer proficient interpretation for their patients.

## Measure 6.A.1

***Activities that do not meet 6.A.1:***

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

## Measure 6.A.2

**Examples:**

- A clinic reviews its patient education materials, after-visit summaries, and preventive service reminders to ensure that these are at an appropriate health literacy level. It translates these materials into a more appropriate reading level, adjusts the font and layout for patients with a range of visual needs, reduces the use of confusing medical terminology, adds (or links to) useful illustrations and guides/definitions, and offers alternative formats/options for patients with visual disabilities.
- A clinic trains its providers and MAs on health literacy principles such as reducing jargon, checking for comprehension, and explaining things in ways that consider their patients' health literacy needs. Staff are trained in health literacy assessment strategies, offering patients opportunities to get clarification, leveraging the help of peers, and/or making patients aware of who they can contact if they have additional questions or need materials in another format.
- A clinic partners with a health literacy consultant to review and update its website and certain patient communication workflows/technologies for health literacy. The clinic also considers health literacy when leveraging or comparing external sources of written templates and communication tools.

***Activities that do not meet 6.A.2:***

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

# Standard 6.B – Education and Self-Management Support

## Measure 6.B.1

**Examples:**

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

***Activities that do not meet 6.B.1:***

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

## Measure 6.B.2

**Examples:**

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

***"Transformation in practice" (best practice example):***

A primary care clinic that serves a culturally and linguistically diverse patient population has struggled to help their newly diagnosed diabetic patients understand how to manage their condition. In response, the clinic seeks out robust educational materials for patients on the

causes, progression, lifestyle changes, and treatment options for diabetes in English, Spanish, and Arabic – the top three languages spoken among patients in the clinic.

In addition to offering patient-specific educational materials about diabetes to their patients, the clinic offers self-management support by training its patients on how to effectively manage diabetes through home monitoring flowsheets and SMARTIE goals.

Finally, the clinic facilitates ongoing *Living Well with Chronic Disease* classes that help patients learn how to implement and practice lifestyle changes like nutrition and exercise to help bring their diabetes under control—with each class attended by relevant interpreters. It also connects patients to local wellness opportunities, such as yoga classes, at a nearby community center.

***Activities that do not meet 6.B.2:***

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

# Standard 6.C – Experience of Care

## Measure 6.C.0

**Example:** A clinic is having difficulty applying patient feedback it receives from survey data to its daily operations and has challenges with patients completing surveys. Staff decide to create an action plan to increase the number of surveys returned per provider. The plan includes a a workflow to engage staff in distributing paper surveys to patients at every upcoming appointment for a specific provider, rotating providers each month. They allow time for monthly data entry and tracking. Every 6 months, the survey data is presented to the clinic staff in a meeting and posted on the quality board in the break room. This helps staff feel engaged in the process, identify areas for improvement, and see their progress.

***Activities that do not meet 6.C.0:***

- A clinic has not collected the minimum survey requirement of 3% of each primary care provider's patient panel within the last two years and does not have a defined a strategy to improve patient response rates.
- A clinic can present clinic-level data but is unable to review individual-provider level data.
- A clinic's survey questions do not cover all four patient experience topics: access to care, provider or health team communication, coordination of care, and staff helpfulness.
- A clinic collects survey data but does not share the survey results with its staff.

## Measure 6.C.1

**Example:** A clinic has two providers, each with a small patient panel, and has developed its own survey using inspiration from the CAHPS survey domains. When its quality team meets to discuss survey results, they find that "Staff Helpfulness" is their lowest scoring domain. Through Plan, Do, Study, Act (PDSA) cycles, they develop training for staff to address the issues and continue to monitor staff helpfulness and share results at their all-staff meetings.

***Activity that does not meet 6.C.1:*** A clinic is unable to demonstrate how survey results are utilized in quality improvement activities.

## Measure 6.C.2

***Activity that does not meet 6.C.2:*** A clinic has a robust survey process that addresses multiple areas of care but cannot identify questions/domains meant to consider/improve health equity.

# Standard 6.D – Communication of Rights, Roles and Responsibilities

## Measure 6.D.0

***Activity that does not meet 6.D.0:*** A clinic only provides the HIPAA grievance policy within its materials rather than a clinic-specific grievance policy and description of patients' rights.

# Standard 6.E – Cultural Responsiveness of Workforce

## Measure 6.E.0

**Examples:**

- A clinic requires that all its primary care providers take a virtual training on how to deliver trauma-informed care at least once every two years.
- As part of its onboarding process, a rural clinic has developed its own training for its primary care providers on the barriers and priorities that local patients face around transportation and food insecurity and how to engage patients in discussions about self-management in a way that acknowledges their more immediate priorities. The clinic offers a "refresher training" every two years for its primary care providers that already received the initial onboarding training.
- A general family medicine clinic requires that each of its primary care providers attend a workshop hosted by a local community-based organization on LGBTQIA2S+ concerns and barriers within the health care system and how to deliver high-quality and identity-affirming care to members of this community. The following year, the clinic has its PCPs take a virtual training on trauma-informed care.

- A clinic decides to offer different (or modified) trainings to its primary care providers based on their role or assigned patient population. For example, two of its providers are bilingual and are typically empaneled with patients who are Latino/a. These two providers receive training every two years on this community's cultural and language norms around mental health, chronic health, and end-of-life care to make sure that conversations and referrals take these into account.
- A youth-oriented clinic partners with a local youth counselor association to train its providers every two years on the evolving concerns that young people face in disclosing sexual health and drug use (e.g., fear of parental retribution) and how to approach conversations about these topics in a way that assures privacy and builds trust.

***Activities that do not meet 6.E.0:***

- A clinic does offer or facilitate training, but not all primary care providers at the clinic receive this training.
- Primary care providers have received training, but it was more than two years ago, and they have not received a refresher or training in any other topic since.

## Measure 6.E.3

**Examples:**

- A Women's Health Center hires three part-time birth doulas, offering to pay the credentialing fees for those who are not yet certified with the OHA to ensure that all doulas are properly credentialed within two years.
- A rural clinic takes steps to identify what types of THW services are available in their area and determines that partnering with a local peer support specialist agency would be especially beneficial to their patient population. They develop a workflow for offering peer support specialists to patients struggling with substance use, and all are trained and credentialed through their agency to facilitate care for this subgroup.
- A clinic determines that its low-income patients are having difficulty navigating their services and that a CHW could improve quality of care, use of preventive services, and adherence to treatment. The clinic partners with their local coordinated care organization to provide CHW services to their OHP patients on a weekly basis.
- A clinic determines that its Latino/a/x patients would benefit from personal health navigators. The clinic develops its own credentialing process for their personal health navigators that includes training around how to best support this subgroup of patients.

***Activities that do not meet 6.E.3:***

- A clinic has utilized the services of a THW in the past, but a THW is not involved in facilitating patient care at the clinic on an ongoing basis.
- A clinic refers patients to an external agency with THWs but does not communicate or collaborate with the THW(s) to facilitate patient care.