



# Patient-Centered Primary Care Home Standards Advisory Committee 2019 Report

# Contents

<b>Executive summary</b> .....	<b>4</b>
<b>Introduction</b> .....	<b>5</b>
Background .....	5
Report overview.....	7
<b>PCPCH Standards Advisory Committee 2019</b> .....	<b>8</b>
Scope of Work.....	8
Key guidelines and considerations.....	8
Committee selection.....	9
<b>Patient-Centered Primary Care Home model</b> .....	<b>10</b>
<b>Revisions to existing standards</b> .....	<b>11</b>
Standard 1.A: In-Person Access .....	11
Standard 1.E: Electronic Access .....	12
Standard 2.A: Performance & Clinical Quality .....	12
Standard 2.B: Public Reporting .....	13
Standard 2.E: Ambulatory Sensitive Utilization .....	13
Standard 3.B: Medical Services.....	14
Standard 3.E: Preventive Services Reminders .....	14
Standard 4.C.0 and 5.B.3: Organization of Clinical Information .....	15
Standard 4.D: Clinical Information Exchange.....	15
Standard 4.G: Medication Reconciliation and Management.....	15
Standard 5.C: Complex Care Coordination .....	16
Standard 5.E: Referral & Specialty Care Coordination.....	17
Standard 6.A: Language/Cultural Interpretation .....	17
Standard 6.B: Education & Self-Management Support .....	18
Standard 6.C: Experience of Care .....	18
Integrating value-based payments (2.A & 2.E) .....	19
Integrating substance use disorder treatment (3.C).....	20
Integrating social determinants of health (3.D).....	21

<b>New standards.....</b>	<b>24</b>
Alternative access .....	24
PCPCH staff vitality.....	25
Oral health integration.....	26
<b>Improving health equity within the PCPCH model .....</b>	<b>28</b>
<b>PCPCH tier revisions .....</b>	<b>30</b>
5 STAR designation criteria .....	30
Tier threshold revisions.....	31
<b>National Committee for Quality Assurance Patient-Centered Medical Home alignment .....</b>	<b>33</b>
<b>Implementation of committee recommendations.....</b>	<b>34</b>
<b>Future areas of focus.....</b>	<b>35</b>

## **Appendices**

Appendix A: PCPCH Program Vision, Mission, and Values

Appendix B: 2019 Standards Advisory Committee Charter

Appendix C: 2019 Standards Advisory Committee Roster

Appendix D: Summary of Proposed Changes to 2017 PCPCH Model

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# Executive summary

In 2009, the Oregon Legislature created the Patient-Centered Primary Care Home (PCPCH) Program through passage of House Bill (HB) 2009 as part of a comprehensive statewide strategy for health system transformation. The PCPCH is Oregon’s version of the “medical home” which is a model of primary care organization and delivery that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety.

After passage of HB 2009, the Oregon Health Authority (OHA) convened a Standards Advisory Committee (committee) to help OHA develop the PCPCH model of care. Committee members included patients, clinicians, health plans and payers. The committee developed six core attributes as well as standards and measures that describe PCPCH care. The core attributes, standards and measures are intended as a tool for OHA, policymakers and other Oregon stakeholders seeking a common framework to assess the degree to which primary care clinics are functioning as primary care homes and promote widespread adoption of the model. OHA reconvened the committee in 2010, 2012 and 2015 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation.

OHA reconvened the committee again from July to December 2019 to develop recommendations on:

1. Revisions to the existing standards and measures based on staff and community experience with the model
2. Integration of value-based payments (VBPs), substance use disorder (SUD) treatment, social determinants of health, alternative visit types, staff vitality and oral health into the model
3. Application of a health equity lens to the PCPCH model and standards, and
4. Revisions to the tier level thresholds and 5 STAR criteria as needed.

The committee’s recommendations on these items are included in this report. Among the proposed changes are the strengthening of existing standards and measures, the addition of three new standards, the revision of the 5 STAR criteria and a redistribution of total available points across five tiers. All recommendations presented in this report are designed to incrementally adapt the model to the changing health care needs of the state, align the model with the best evidence where it is available and improve the effectiveness of the standards and measures overall. The inclusion of VBPs, SUD treatment, social determinants of health, alternative visit types, staff vitality and oral health are a response to needs identified by stakeholders across Oregon, growing evidence of impact and Oregon’s top state priorities for health system transformation efforts such as CCO 2.0<sup>1</sup>.

These recommendations will inform the next iteration of the PCPCH recognition criteria which will be released in 2020. OHA will consider proposals in this report as well as stakeholder feedback to determine final revisions to the PCPCH model.

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<sup>1</sup> Oregon Health Authority. (2018). [CCO 2.0 Recommendations of the Oregon health Policy Board](#).

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# Introduction

## Background

The Oregon Health Fund Board (OHFB) was formed in 2007 at the direction of the Oregon Legislature to develop a comprehensive plan to reform Oregon’s health care system. OHFB identified stimulating innovation and improvement within the health care delivery system as a key building block to achieving the “Triple Aim” of health care reform: a healthy population, extraordinary patient care for everyone and reasonable costs shared equitably.<sup>2</sup>

OHFB identified development of primary care medical homes as a central strategy to improve the health care delivery system.

The conceptual work of the OHFB on primary care homes was incorporated into legislation enacted during the 2009 legislative session. [House Bill \(HB\) 2009](#) created the Oregon Health Authority (OHA), established the Oregon Health Policy Board and established a Patient-Centered Primary Care (PCPCH) Home program within OHA.

The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for transformative, whole-person and evidence-based care. The PCPCH Program’s complete vision, mission and values is included in Appendix A.

In 2009, the OHA Director appointed a 15 member [PCPCH Standards Advisory Committee](#) (committee) to help OHA develop strategies to identify and measure primary care homes. The committee was made up of diverse Oregon stakeholders including patients, clinicians, health plans and purchasers.

OHA tasked the committee with the following:

- Define the core attributes of a PCPCH to promote a reasonable level of consistency of services provided by patient-centered primary care homes.
- Develop a process to identify that a PCPCH meets core attributes as defined by OHA.
- Define uniform quality measures for a PCPCH that build from national measures and allow for standard measurement of PCPCH performance.
- Define uniform quality measures for acute care hospital and ambulatory services that align with PCPCH quality measures.
- Create policies that encourage retention and growth in the numbers of primary care providers.

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<sup>2</sup> Oregon Health Fund Board. (2008). [Delivery Systems Committee Recommendations: Report to the Oregon Health Fund Board](#).

Over the course of seven meetings between October 2009 and January 2010, the committee developed six core attributes and standards that describe care delivered by a PCPCH. These six core attributes are:

1. Accessibility to care,
2. Accountability,
3. Comprehensive whole person care,
4. Continuity,
5. Coordination and integration, and
6. Person and family centered care.

Using the framework of the core attributes and standards, the committee also developed a set of detailed PCPCH measures. The committee expressed its core attributes and standards in patient-centered language to help communicate the benefits of this new model of care to the public.

Cognizant of the evolving evidence base that supports the effectiveness of the medical home model and the need to continuously improve and adapt the model to the health care needs of Oregonians, OHA reconvened the committee in 2010, 2012 and 2015 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation.<sup>3</sup>

PCPCHs are a foundational component of the [Coordinated Care Model](#) (CCM) Oregon has adopted through [Coordinated Care Organizations](#) (CCOs) as the basis for transformation. CCOs are community-based organizations that include all types of health care providers who have agreed to work together in their local communities for persons who receive health care coverage under the Oregon Health Plan (Medicaid). As part of this model, OHA encourages CCOs to use recognized PCPCHs for primary care delivery to the greatest extent possible in their networks. Approximately 96 percent of CCO members receive primary care through a recognized PCPCH.<sup>4</sup>

In 2017, Oregon Governor Kate Brown identified four key focus areas for health system transformation efforts: (1) improve the behavioral health system, (2) increase value and pay for performance, (3) focus on social determinants of health and health equity and (4) maintain sustainable cost growth. These priorities guided the PCPCH model proposals introduced to this 2019 committee including the integration of value-based payments, SUD treatment, social determinants of health and health equity and oral health into primary care settings. Other recommendations such as the inclusion of alternative visit types and staff vitality in the PCPCH model are a response to needs identified by stakeholders across Oregon and growing evidence of impact.<sup>5</sup>

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<sup>3</sup> Oregon Health Authority. (2013). Standards and Measures for Patient Centered Primary Care Homes: [Final Report of the Patient-Centered Primary Care Home Standards Advisory Committee October 2012](#).

<sup>4</sup> Oregon Health Authority. (2019). Oregon Health System Transformation: [CCO Metrics 2018 Final Report](#).

<sup>5</sup> Oregon Health Authority. (2018). [CCO 2.0 Recommendations of the Oregon health Policy Board](#).

# Report overview

In 2019, OHA reconvened the committee to aid with model refinement as the state continues with health care delivery system transformation. This report contains proposed revisions to PCPCH model standards and measures recommended by the 2019 committee. Also included in this report are proposed standards and revisions to further support the integration of value-based payments (VBPs), substance use disorder (SUD) treatment, social determinants of health, alternative visit types, staff vitality and oral health care into the model.

OHA will determine final revisions to the PCPCH model with consideration of the proposals presented in this report, additional stakeholder feedback and alignment with state priorities and national efforts to transform primary care.

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# PCPCH Standards Advisory Committee 2019

## Scope of Work

In 2019, OHA tasked the committee with developing recommendations on the following:

1. Revisions to the existing standards and measures based on staff and community experience with the model
2. Integration of value-based payments (VBPs), substance use disorder (SUD) treatment, social determinants of health (SDOH), alternative visit types, staff vitality and oral health into the model
3. Application of a health equity lens to the PCPCH model and standards and
4. Revisions to the tier level thresholds and 5 STAR criteria as needed.

The committee charter is included in Appendix B of this report.

## Key guidelines and considerations

In addition to the specific language in HB 2009, OHA required the committee to frame its work based on the following guidelines and considerations:

- The committee should incorporate new evidence, where possible, into the model.
- The rigor of the model should increase to incentivize practices to continue along the transformation process, while still supporting those occupying lower tier levels.
- The committee should focus on standards and measures, recognizing that technical specifications consistent with the recommendations of the committee will be developed at a later time.
- The model should minimize the burden of reporting when possible, while recognizing that measuring data in a standardized way allows for the model to be replicated and confirmed.
- Standards and measures developed by the committee should be sufficiently broad to be applicable to primary care clinics of different sizes, with different patient populations and in different geographic regions across Oregon. Standards and measures should build on existing PCPCH model, health system transformation and quality measurement work in Oregon and seek to be broadly acceptable to all major stakeholders.

- While the committee will not consider payment reform specifically, standards should be developed with the goal of being used by public and private payers seeking to implement primary care payment reform to support the PCPCH model.

## Committee selection

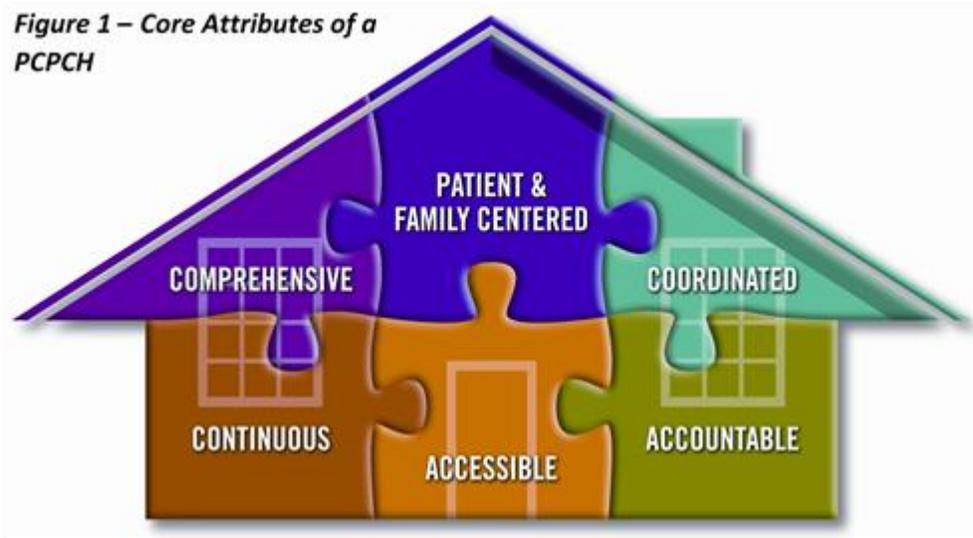
Committee applicants were drawn from past committee rosters, an open call for nominations and contacts made to stakeholders such as providers, content experts and patients. OHA Director Pat Allen appointed the 2019 committee members, which are included in Appendix C. The committee met seven times from July 2019 until December 2019 in Portland.

Selected committee members and content experts will comprise a Technical Assistance Group (TAG) to assist program staff with updating the accompanying PCPCH Recognition Criteria Technical Assistance and Reporting Guidelines for select measures.

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# Patient-Centered Primary Care Home (PCPCH) model

The PCPCH model of care delivery is based on six core attributes (Figure 1) and a number of standards and measures. The core attributes help to define the specific measures within each standard and also guide practices on their transformational path. The measures are intended as a functional tool that can be used to recognize clinics currently delivering primary care home functions and support payment reform or other incentives that will drive an increasing number of clinics towards functioning as advanced primary care homes.



All PCPCHs must meet 11 “must pass” measures. These measures reflect the most essential elements of the PCPCH model. There are five levels, or tiers, of PCPCH recognition a clinic can achieve depending on what measures of the model they have attested to. With the exception of the 11 “must pass” measures, each measure has a point value. The total points a clinic accumulates on their application determines their overall tier of PCPCH recognition.

At the time of this report, 648 clinics across the state have been recognized as a PCPCH.

In preparation for the 2019 committee meetings, PCPCH Program staff drafted proposed revisions to the 2017 PCPCH model standards and measures for the committee’s consideration. Program staff reviewed literature to provide an evidence base for the proposed revisions. Among the other inputs for the proposed revisions included a review of the [National Committee for Quality Assurance \(NCQA\) Patient-Centered Medical Home \(PCMH\)](#) standards, feedback from stakeholders, providers and clinics in Oregon and information gathered by program staff during PCPCH site visits.

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# Revisions to existing standards

Using the PCPCH model core attributes as a framework, the committee evaluated the proposed revisions to the standards and measures and provided recommendations to OHA on adoption of these revisions. This section of the report includes a brief summary of the key committee discussion points for the proposed revisions and the rationale and evidence for the final committee recommendations. Please refer to Appendix D for a comprehensive table of the recommended revisions to the PCPCH model standards and measures. If OHA adopts all the proposed changes the total available points in the revised PCPCH model will increase from 380 to 425.

## Standard 1.A: In-Person Access

Current measures:

- 1.A.1 - PCPCH surveys a sample of its population on satisfaction with in-person access to care. (5 points)
- 1.A.2 - PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care. (10 points)
- 1.A.3 - PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care. (15 points)

Understanding and improving upon patients, caregivers and families' access to in-person care is an important function of primary care. To ensure that clinics are meeting the intent of this standard and eliminate the redundancy between this and must-pass standard 6.C.0, the committee recommends that OHA revise the measures in this standard to focus on tracking and improving timely access to and communication with clinical staff instead of surveying patients. The committee also recommends OHA remove measure 1.A.3 if the committee's proposal for the new Standard 1.G.3 is adopted since alternative access will be addressed there. Additional suggestions for the technical specifications include: 1) adding two tables with suggested targets for front-end communication and access to appointments, 2) ensuring that these targets align with existing system standards wherever possible, 3) requiring that clinics be able to define critical access issues, and 4) accepting multiple tracking methods in addition to those generated by Electronic Health Records (EHRs).

## Standard 1.E: Electronic Access

Current measure:

- 1.E.1 – PCPCH provides patients with an electronic copy of their health information upon request using a method that satisfies either Stage 1 or Stage 2 Meaningful Use measures. (5 points)

The Centers for Medicare & Medicaid Services (CMS) EHR Incentive Program, commonly referred to as meaningful use, was transitioned to become one of the four components of the Merit-Based Incentive Payment System (MIPS) through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This renders the language and benchmarks in Standard 1.E outdated. The committee therefore recommend OHA revise Standard 1.E to include all types of electronic access and remove the 10 percent minimum that was required through meaningful use objectives. The committee also recommends that OHA include definitions of “health information” and “downloading and transmitting” in the technical specifications of the standard. OHA’s Office of Health Information Technology (OHIT) staff were consulted on this recommendation.

## Standard 2.A: Performance & Clinical Quality

Current measures:

- 2.A.0 - PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures. (Must-Pass)
- 2.A.1 - PCPCH tracks and reports to the OHA two measures from core set and one measure from the menu set of PCPCH Quality Measures. (5 points)
- 2.A.2 PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures. (10 points)
- 2.A.3 - PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (15 points)

Measuring and improving on clinical quality is a foundational element of primary care homes. Given that 73% of clinics attest to the highest measure of this standard, the committee recommends that OHA modify the standard to encourage and reward continual improvement on quality metrics. Suggestions along this line include requiring all PCPCHs to track and report on three quality metrics instead of one (rendering 2.A.1 now 2.A.0), absorbing the language of 2.A.2 into 2.A.3 which should require improvement on at least one quality metric, and making this standard a “check all that apply.” The committee recommends that the definition of improvement in 2.A.3 be based in the [Oregon Health Authority Improvement Targets](#) formula as this takes into consideration how close to the benchmark a clinic is performing at baseline. The committee also recommends that OHA update the quality metrics set and eliminate the division of metrics into “core” and “menu.” For the technical specifications the committee suggests that OHA assign an improvement floor to each metric and provide a benchmark for all metrics. Additional recommendations for this standard are included in the “Integrating Value-Based Payments” section of this report.

## Standard 2.B: Public Reporting

Current measures:

- 2.B.1 - PCPCH participates in a public reporting program for performance indicators. (5 points)
- 2.B.2 - Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes. (10 points)

Making performance data available to the public in a way that allows for comparison across clinics helps to increase health care transparency and hold PCPCHs accountable to their patients and communities. Since most practices already attest to Measure 2.B.2 and are automatically opted-in to a statewide public reporting program, the committee recommends that OHA combine 2.B.1 and 2.B.2 into one measure (2.B.1). Suggestions for the technical specifications include being explicit about which clinics are opted-in to this reporting program, instructions for clinics with less than three providers regarding how they can opt-in, a list of other public reporting programs or avenues that clinics could use to meet this standard, which performance indicators would need to be included and resources for national comparisons.

## Standard 2.E: Ambulatory Sensitive Utilization

Current measures:

- 2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population. (5 points)
- 2.E.2 - PCPCH tracks selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization. (10 points)
- 2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures. (15 points)

PCPCHs play a critical role in “bending the cost curve” by ensuring that ambulatory conditions are treated well, to the patients’ satisfaction and in the most cost-effective setting. However, PCPCH staff has found that few clinics attest to Standard 2.E due to systemic barriers to obtaining meaningful utilization data and limited utilization metric choices. The committee therefore recommends OHA increase engagement with this standard by rewarding clinic processes that address adverse or unexpected utilization patterns rather than solely the acquisition of utilization data (2.E.2) and expanding the menu of utilization metrics. The committee also recommends OHA ensure the utilization metrics are broad enough to apply to clinics with smaller patient populations or with limited access to claims data. In addition, the committee recommends OHA make this standard a check-all-that-apply since clinics can meet the proposed measures independently. Additional recommendations for this standard are included in the “Integrating Value-Based Payments” section of this report.

## Standard 3.B: Medical Services

Current measure:

- 3.B.0 - PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support. (Must-Pass)

Oregon experiences low rates of recommended immunizations—particularly among children and adolescents.<sup>6</sup> Clinics' accountability to the preventive care of their patients is a core attribute of the PCPCH model. Since vaccines are an essential aspect of preventive care, the committee recommends OHA include CDC-recommended, age-appropriate immunizations to the list of primary care services all PCPCHs must make available. Clinics that cannot provide recommended vaccines onsite should be required to show evidence of closed-looped referrals to partnering organizations to demonstrate that appropriate coordination of these services is being provided, particularly for populations that have limited access to vaccines through other routes such as pharmacies.

## Standard 3.E: Preventive Services Reminders

Current measures:

- 3.E.1 - PCPCH sends reminders to patients for preventative/follow-up care using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. (5 points)
- 3.E.2 - PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders and to proactively advise patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders. (10 points)
- 3.E.3 - PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services. (15 points)

As new measures are added to the program, measures that are no longer as innovative today as they once were should be removed. In general, clinics do not send out preventive service reminders but then fail to follow up with patients. The committee therefore recommends that OHA remove the first measure—Standard 3.E.1—from Standard 3.E. The committee also calls for clarity in the technical specifications regarding what types of documentation should be accepted for verification purposes and examples of what types of actions do not meet its intent.

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<sup>6</sup> America's Health Rankings. (2008). Immunizations in Oregon. Retrieved at <https://www.americashealthrankings.org/explore/annual/measure/immunize/state/OR?edition-year=2018>

## Standards 4.C.0 and 5.B.3: Electronic Health Record

Current measure in Standard 4.C: Organization of Clinical Information

- 4.C.0 - PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit. (Must Pass)

Current measures in Standard 5.B: Electronic Health Record

- 5.B.3 - PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be “meaningful users” of certified electronic health record technology established by the Centers for Medicare and Medicaid Services. (15 points)

Implementation and use of an EHR is an essential tool for achieving many advanced primary care home functions such as improved population tracking, care coordination, improved communication and patient safety. With this in mind, the committee recommends that OHA combine Standard 4.C.0 and 5.B.3 into one “must pass” measure (Standard 4.C.0) which would require PCPCHs to utilize a CMS-certified EHR. OHA’s OHIT staff were consulted on this recommendation.

## Standard 4.D: Clinical Information Exchange

Current measure:

- 4.D.3 - PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange). (15 points)

Continuity of health care information during care transitions is important for both patient safety and reducing unnecessary utilization of services. PCPCH staff suggested removing the “real-time” and “bi-directional” requirements from this measure to encourage the use of any type of electronic records exchange. However, it is the opinion of the committee that these two features can significantly improve care and should continue to be encouraged and recognized among clinics that pursue them. The committee therefore recommends that OHA leverage the tiered structure present in other standards, keeping Standard 4.D.3 (15 points) as-is and creating a 4.D.2 (10 points) for clinics that do not have the bi-directional, real time electronic exchange. OHA’s OHIT staff were consulted on this recommendation.

## Standard 4.G: Medication Reconciliation and Management

Current measures:

- 4.G.1 - Upon receipt of a patient from another setting of care or provider of care (transitions of care) the PCPCH performs medication reconciliation using a method that satisfies either Stage 1 or Stage 2 meaningful use measures. (5 points)

- 4.G.2 - PCPCH develops a process, tracks and reports the percentage of patients whose medication regimen is reconciled at each relevant patient encounter. (10 points)
- 4.G.3 – PCPCH provides Comprehensive Medication Management for appropriate patients and families. (15 points)

To reduce the significant health problems that can result from medication errors, such as during care transitions or the management of complex medication regimens, it is important that PCPCHs be recognized for engaging in medication reconciliation and management practices. The CMS EHR Incentive Program, commonly referred to as meaningful use, was transitioned to become one of the four components of MIPS, through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The committee recommends that OHA remove 4.G.1 from the standard in line with this change as well as the insufficient value that it has brought to patients in practice. In addition, due to the significant administrative burden that tracking medication reconciliation can pose to clinics, the committee recommends that OHA revise the overall standard to focus on providing medication reconciliation for those in most need of this service (patients with complex or high-risk medication concerns) rather than on tracking the percentage of total patients that receive this service. Finally, the committee recommends that OHA replace “provider” with “qualified health professional” within the technical specifications and provide best practices or strategies to pediatric clinics on how they may meet measure 4.G.3.

## Standard 5.C: Complex Care Coordination

Current measures:

- 5.C.1 - PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient or family the name of the team member(s) responsible for coordinating his or her care. (5 points)
- 5.C.2 - PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (10 points)
- 5.C.3 - PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self-management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness. (15 points)

Individualized care plans can help patients with complex medical and social needs avoid exacerbations of illness and improve their health. However, PCPCH program staff are often unable to verify this measure during site visits due to clinics’ confusion about the required care plan components described in the measure language. The committee therefore recommends that OHA incorporate a broader array of care plan components for clinics to choose from and include these in the technical specifications instead of the measure language. In addition, the committee recommends that OHA change the measure language to reflect a more collaborative process that positions patients at the center of their care plan development. The committee also supports encouraging clinics to involve a patient’s entire care team and/or external providers and specialists in the development or awareness of their care plan. Finally, the committee

recommends that OHA convene a Technical Advisory Committee to develop the technical specifications for this standard, including additional guidance on the intended population for care plans and the best practice of including care plans in patient portals.

## Standard 5.E: Referral & Specialty Care Coordination

Current measures:

- 5.E.1 - PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. (5 points)
- 5.E.2 - PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility). (10 points)
- 5.E.3 - PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services. (15 points)

If the committee's proposed revisions to the new Standard 3.D - Comprehensive Health Assessment & Intervention are adopted by OHA, the activities inherent in measure 3.D.3 will duplicate some of the activities that are currently recognized in measure 5.E.3. With this in mind, PCPCH staff initially proposed removing 5.E.3 from the model. The committee, however, recommends that OHA leave it in the model as deleting it would remove assessments and referrals to health services such as dental, pharmacy, education, behavioral health and others that would likely not qualify as health-related social needs. The committee also recommends that OHA expand the list of specialized settings in 5.E.2 to include foster care (both adult or child), school-based health centers, and behavioral health providers & organizations, and revising the list of specialized settings in 5.E.3 to include traditional health workers (updated from non-traditional health workers) and behavioral health providers & organizations.

## Standard 6.A: Language/Cultural Interpretation

Current measures:

- 6.A.0 - PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice. (Must-Pass)
- 6.A.1 - PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population. (5 points)

There is strong evidence to support the benefits of translating written materials into patients' first languages.<sup>7</sup> At PCPCH site visits, PCPCH program staff have found that some clinics meet

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<sup>7</sup> Oregon Health Authority (2013). Standards and Measures for Patient-Centered Primary Care Homes: [Final Report of the Patient-Centered Primary Care Home Standards Advisory Committee of 2012](#).

the intent of measure 6.A.1 but lack the patient population demographics to meet the threshold requirements. The committee therefore recommends OHA remove the “5% of a practices’ patient population” threshold and instead require that clinics translate materials into “language(s) spoken by at least 30 households or the top 2 non-English languages of the clinic’s patient population.” In addition, the committee suggests OHA include threshold language in the technical specifications only (rather than the measure language itself). Suggestions for the technical specifications include guidance on translation strategies such as materials-sharing across clinics. Additional recommendations for this standard including the change to its title are included in the “Improving Health Equity” section of this report.

## Standard 6.B: Education & Self-Management Support

Current measures:

- 6.B.1 - PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate. (5 points)
- 6.B.2 - More than 10% of unique patients are provided patient-specific education resources. (10 points)
- 6.B.3 - More than 10% of unique patients are provided patient-specific education resources and self-management services. (15 points)

A critical component of person- and family-centered care is empowering patients and their families to manage their own health and wellness through patient engagement and self-management support. However, tracking the percentage of patients provided with these services poses a significant administrative burden on clinics and is not necessarily needed to meet the intent of the standard. With this in mind, the committee recommends that OHA remove percentage-related language from the measures and include important thresholds (such as the proportion of patients receiving patient-specific education) in the technical specifications instead. The committee also recommends that OHA encourage clinics to leverage existing community programs, which are sometimes underutilized, in cases where these are of high quality and/or preferred by patients.

## Standard 6.C: Experience of Care

Current measures:

- 6.C.0 - PCPCH surveys a sample of its patients and families at least every two years on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools. (Must-Pass)

- 6.C.2 - PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process. (10 points)
- 6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process, and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness. (15 points)

To be truly person- and family-centered, a primary care home should understand the care experiences of its patients and their family members and seek to improve the care experience where appropriate. There was some debate within the committee regarding the extent to which the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey tool should be incorporated into this standard due to its administrative complexity and lag in feedback. Some staff and committee members advocated it continue to be leveraged to offer clinics guidance, benchmarking and a standard method to assess the safety of their services. To ensure clinics that do not use CAHPS are still meeting the intent of this standard, the committee recommends OHA add a 5-point measure to the standard (6.C.1) with similar expectations as 6.C.2 but without the CAHPS requirement. In addition, the committee recommends that: 1) OHA move the “two years” timeline to the technical specifications, 2) require all clinics to share data with staff, 3) change the 25-per-provider minimum to a percentage (3%) of each provider’s panel (to establish parity for providers with smaller panels), 4) require clinics who attest to 6.C.3 to share survey data with patients and 5) include resources in the technical specifications for survey strategies.

## Integrating value-based payments (VBPs)

Value-based payments (VBPs) have been a focus for national and state-wide initiatives in recent years. Governor Kate Brown called out “increasing value and pay for performance” as one of the four key areas of focus for health system transformation efforts in coming years. Beginning in 2020, CCOs will be required to meet individualized annual VBP growth targets and provide per-member-per-month VBP payments to PCPCH clinics. Additional state initiatives such as the [Primary Care Transformation Initiative](#) are leveraging multi-stakeholder feedback to increase private payer engagement in VBP arrangements with primary care providers.

PCPCH Program staff have proposed incorporating VBP arrangements into Standard 2.A to incentivize and reward clinic-level efforts to improve quality, and Standard 1.E to foster increased alignment of incentives, clinical performance and frontline team quality improvement work. The committee supports this step towards health system transformation but recommends OHA ascribe a low point-value (5 points) to VBP arrangements since clinics currently experience inequitable opportunities to establish VBP contracts due to different policies and expectations among payers. It is the hope of this committee that VBP opportunities become more commonplace and accessible to all clinics over time. The final recommended measures and point values for these standards are:

## Standard 2.A: Performance and Clinical Quality

- 2.A.1 – PCPCH engages in a Value-Based Payment arrangement with payers covering a significant portion of the clinic population that includes three measures from the set of PCPCH Quality Measures. (5 points)

## Standard 2.E: Ambulatory Sensitive utilization

- 2.E.1 – PCPCH engages in a Value-Based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure. (5 points)

# Integrating substance use disorder treatment

Although over 21 million persons in the United States have substance use disorders, most persons with addiction do not receive treatment.<sup>8</sup> Oregon has the fourth highest rate of illegal opioid use in the United States. The [Oregon Substance Use Disorder Research Committee](#) found that the state’s rate for alcoholism is higher than the national average. One in 10 Oregonians abuses alcohol or drugs. However, only 11 percent of the population receives treatment, which is below the national average of 14 percent.<sup>9</sup>

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some persons struggling with addiction, MAT can help sustain recovery.<sup>10</sup> The Agency for Healthcare Research and Quality (AHRQ) has reviewed several models of MAT integration into primary care settings that could be considered for adaptation across diverse health care settings.<sup>11</sup>

It is the opinion of the committee that SUD treatment be more of a focus within the PCPCH model. Some committee members feel OHA should create a tiered, stand-alone standard around SUD treatment to guide clinics through the scope of services and varying levels of primary care engagement in this area. Others feel this approach runs the risk of siloing behavioral health, developmental health and substance abuse when these are inherently intertwined. The committee did not reach a consensus on this topic.

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<sup>8</sup> Saitz, R., & Daaleman, T. P. (2017). [Now is the Time to Address Substance Use Disorders in Primary Care](#). *The Annals of Family Medicine*, 15(4), 306–308.

<sup>9</sup> The Recovery Village Ridgefield. (2018). [Substance Use Disorder in Oregon: What the Data Reveals](#).

<sup>10</sup> Substance Abuse and Mental Health Services Administration. (2019). [Medication and Counseling Treatment](#). *U.S. Department of Health & Human Services*.

<sup>11</sup> Korthuis, P., et al. (2016). [Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review](#). *Annals of Internal Medicine*, 166(4):268–278.

At the minimum, the committee recommends OHA add a 10-point measure to Standard 3.C (see measure language below) recognizing clinics that address SUD in primary care through pharmacotherapy, behavioral counseling and referral to recovery support. The committee also recommends that OHA revise the language in the current 3.C.2 to encourage more engagement with behavioral health services.

Current measures in Standard 3.C – Behavioral Health Services:

- 3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes (Must-Pass)
- 3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers (10 Points)
- 3.C.3 - PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers (15 Points)
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There was some debate within the committee as to whether this new SUD measure should be weighted at more points than the revised 3.C.2 (which would render it 3.C.1 instead). Some committee members asserted that the transition to and management of onsite SUD treatment requires more administrative effort than the coordination of behavioral health services, while others felt that the value behavioral health services bring to the entire patient population warrants a higher point level—with the final recommendation being that OHA weight both measures at 10 points. PCPCH staff clarified that point levels are not a reflection of the value a measure brings to patient populations. Finally, the committee recommends that OHA convene a Technical Advisory Committee to develop the technical specifications for this standard— suggestions for which include definitions, what qualifies as MAT and examples of recovery supports.

## Integrating social determinants of health

More health care institutions and systems are beginning to respond to the reality that much of our health is shaped by the social, economic, political and environmental conditions in which persons are born, grow, work, live and age—factors collectively referred to as the social determinants of health (SDOH). Oregon has made the SDOH a major focus in recent health transformation efforts such as requiring CCOs increase their investments over the next five years in strategies to address social determinants of health and health equity.<sup>12</sup>

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<sup>12</sup> Oregon Health Authority. (2018). [CCO 2.0 Recommendations of the Oregon health Policy Board](#).

## Targeting health-related social needs (HRSN)

Given the systemic nature of the SDOH, interventions aimed at addressing these factors tend to veer towards community- or societal-level economic and policy changes.<sup>13</sup> While these types of interventions are typically outside the scope and capacity of primary care practices, clinics do have opportunities to address individual-level social and economic barriers to health, also known as “health-related social needs” (HRSN).<sup>14</sup> HRSNs such as housing instability, food insecurity and exposure to interpersonal violence drive health care utilization and directly impact health outcomes.<sup>15</sup> By focusing on these needs, PCPCHs can help improve our understanding of the relationship between clinic-level interventions and health outcomes—allowing for comparisons across health systems to support learning, improvement and research.

A substantial proportion of health care to underserved populations is provided by primary care providers. These providers and their care teams are in a powerful position to impact their patients’ HRSN by integrating clinical care, public health, behavioral health and community-based services. Clinicians routinely employ standardized questions and validated assessment tools to screen for clinical and behavioral drivers of poor health such as alcohol dependency and depression, but screening for HRSNs is not yet standard clinical practice. Standardized application of screening tools as a part of clinical routines allows provider teams to quickly and consistently identify possible social health needs for further investigation and intervention. Several resources and tools are available for providers and their practice teams to aid them in these efforts.<sup>16</sup>

To integrate HRSNs into the PCPCH model, PCPCH staff have proposed revising Standard 3.D to focus on addressing HRSNs in primary care settings. The committee supports this proposal and recommends that OHA ensures the measure language reflects the varying resources and capacity of clinics in different regions and of different sizes, while still recognizing more robust interventions at higher point levels. The committee also recommends the measure language be broad enough to capture efforts to address HRSNs which may fall outside of conventional screening practices, and would like to see examples of appropriate HRSNs and interventions in the Technical Assistance Guide. The final recommended measures and point values for Standard 3.D. are:

### Standard 3.D: Comprehensive Health Assessment and Intervention

Current measure:

- 3.D.1 - PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors. (5 points)

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<sup>13</sup> Garg, A., et al. (2013). [Addressing the Social Determinants of Health Within the Patient-Centered Medical Home: Lessons from Pediatrics](#). *Jama*, 309(19):2001.

<sup>14</sup> Perla, R. (2017). [Defining Success in Resolving Health-Related Social Needs](#). Health Affairs.

<sup>15</sup> Billioux, A., et al. (2017). [Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool](#). National Academy of Medicine.

<sup>16</sup> American Academy of Family Physicians (2018). [Addressing Social Determinants in Primary Care](#).

Recommended measures:

- 3.D.1 - PCPCH has a routine assessment to identify health-related social needs in their patient population. (5 points)
- 3.D.2 – PCPCH tracks referrals to outside community-based agencies or referrals to care coordination within the PCPCH. (10 points)
- 3.D.3 - PCPCH describes and demonstrates its process for health-related social needs risk factor interventions and coordination of resources for patients with health-related social needs. (15 points)

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# New standards

## Alternative access

Access to primary care is a core attribute of the PCPCH model. While increasing access to traditional, onsite appointments is an important step towards improved health, patients often face barriers such as physical limitations, geographic location, transportation, work schedules and health conditions. About 35 percent of Oregonians, for example, live in rural and frontier communities which tend to have fewer per-capita providers<sup>17</sup> and limited transportation options.<sup>18</sup> Some clinics have responded by offering alternative visit types that do not require patients travel to their clinic to receive care.

Alternative visits types such as home visits, telemedicine services and other types of interactions between providers and patients can sometimes take the place of a traditional one-on-one clinic visit with a physician. Online communication methods and telemedicine can be used to manage patients with chronic conditions<sup>19</sup> and a 2019 HITEQ review found that services delivered via telehealth are comparable to in-person care.<sup>20</sup> The American Academy of Family Physicians (AAFP) supports enhanced-access physician-patient interactions including electronic visits or “virtual e-visits” which occur over safe, secure, online communication systems.<sup>21</sup> Despite the capacity of telehealth to improve access to care, there has been limited adoption among health centers due to perceived lack of need, information and training around the topic.<sup>22</sup>

PCPCH staff have proposed a new standard intended to award clinics who offer alternative office visit types to their patients. The committee supports this proposal and recommends that OHA make this a tiered standard to encourage system development, with distinct point values awarded to clinics for assessing the need among their patient population and subsequently developing and implementing services that meet those needs. The committee also recommends the measures be written broadly enough to remain relevant in this rapidly-developing domain of service. There was some debate about whether “e-visits” or “patient portals” should be included in the first level of this standard; if so, the committee recommends clearly defining the rigor and expectations in the technical specifications. The final recommended measures and point values for Standard 1.G are:

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<sup>17</sup> Oregon Health Authority. (2017). [Oregon’s primary care workforce: Based on data collected during 2015 and 2016](#).

<sup>18</sup> Oregon Health Authority. (2018). [Oregon’s State Health Assessment 2018](#).

<sup>19</sup> Institute for Healthcare Improvement. (2020). [Decrease Demand for Appointments](#).

<sup>20</sup> Shigekawa, E., Fix, M., Corbett, G., Roby, D., & Coffman, J. (2019). [The Current State of Telehealth Evidence: A Rapid Review](#). *Health Information Technology, Evaluation, and Quality Center*.

<sup>21</sup> American Academy of Family Physicians. (2018). [Virtual e-Visits](#).

<sup>22</sup> Shigekawa, E., Fix, M., Corbett, G., Roby, D., & Coffman, J. (2019). [The Current State of Telehealth Evidence: A Rapid Review](#). *Health Information Technology, Evaluation, and Quality Center*.

## Standard 1.G: Alternative Access

- 1.G.1 - PCPCH regularly offers patient portal messaging and identifies patient populations that would benefit from additional alternative appointment types (5 points).
- 1.G.2 - PCPCH regularly offers at least one alternative to traditional office visits that meet the needs of their patient population and increases access to clinical staff and care teams (10 points).

Finally, the committee recommends that the OHA convene a Technical Advisory Committee to develop the technical specifications for this standard—suggestions for which include a menu of alternative visit types, requiring patient involvement in the development of services and defining the eligible workforce to include both clinical and non-licensed staff.

## PCPCH staff vitality

According to a 2018 Medscape survey, Oregon ranks among the top ten states in proportion of physicians experiencing burnout or “a feeling of physical, emotional, or mental exhaustion as well as a frustration and cynicism related to work and doubts about [their] competence and the value of [their] work.”<sup>23</sup> Provider burnout can result in significant consequences for clinic staff including a diminished sense of personal success, premature departure from their jobs, substance abuse, depression, post-traumatic stress disorder and suicide. Burnout may also result in lower quality care to patients due to high staff turnover, increased medical errors, increased risk of malpractice and reduced patient satisfaction.<sup>24</sup>

Provider burnout can result from a variety of work-related stressors related to the nature of the work, personal characteristics and organizational factors.<sup>25</sup> A growing body of research suggests that both individual-focused and structural or organizational strategies can result in meaningful reductions in burnout.<sup>26</sup> Research includes strategies for increasing staff satisfaction with some of the processes and workflows encouraged by medical home models such as the PCPCH Program.<sup>27</sup>

PCPCH staff proposed a new standard to recognize clinics that engage in activities that support the safety, well-being, work satisfaction, growth and overall morale of their staff. The committee supports this proposal and recommends that OHA makes this a tiered standard with distinct point values awarded to clinics for assessing the need among their staff and subsequently developing, implementing and evaluating services that meet those needs. The

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<sup>23</sup> Peckham, C. (2018). [Best & Worst Places to Practice 2018: Happiness in Work and Home Life](#). *Medscape*.

<sup>24</sup> Patel, R. S., Bachu, R., Adikey, A., Malik, M., & Shah, M. (2018). [Factors Related to Physician Burnout and Its Consequences: A Review](#). *Behavioral sciences (Basel, Switzerland)*, 8(11), 98.

<sup>25</sup> Patel, R. S., Bachu, R., Adikey, A., Malik, M., & Shah, M. (2018). [Factors Related to Physician Burnout and Its Consequences: A Review](#). *Behavioral sciences (Basel, Switzerland)*, 8(11), 98.

<sup>26</sup> West, C., Dyrbye, L., Erwin, P., Shanafelt, T. (2016). [Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis](#). *The Lancet*, 388(10057), 2272-2281.

<sup>27</sup> Ferrante, J., Shaw, E., Bayly, J., Howard, J., Quest, M., Clark, E., Pascal, C. (2018). [Barriers and Facilitators to Expanding Roles of Medical Assistants in Patient-Centered Medical Homes \(PCMHs\)](#). *Journal of the American Board of Family Medicine*: 31 (2) 226-235

committee also recommends that OHA require clinics to act on the results of their assessment at every level of the standard to avoid increasing staff burnout. Suggestions for the technical specifications include best practices around successful leadership tactics and information about trauma-informed care. The final recommended measures and point values for Standard 2.F are:

## Standard 2.F: PCPCH Staff Vitality

- 2.F.1 - PCPCH uses a structured process to identify opportunities to improve the vitality of their staff. (5 points)
- 2.F.2 - PCPCH develops, implements and evaluates a strategy to improve the vitality of their staff. (10 Points)

## Oral health integration

A growing body of evidence shows oral health is critical to overall health. Research suggests gum disease and other oral health conditions are associated with heart disease, diabetes, low birth weight and certain types of cancers. Poor oral health also contributes to missed school or work days and can have a negative impact on overall well-being. Individuals with low income are disproportionately likely to experience poor oral health and persons of color can face even worse health outcomes.<sup>28</sup>

Despite this connection, oral health care has traditionally been delivered separately from medical care. A key goal of Oregon's Coordinated Care Organizations (CCO) is to integrate physical, oral and behavioral health care to treat the whole person. In 2014, CCOs began managing dental benefits for their members, mainly by contracting with existing dental plans called dental care organizations (DCOs).

Over the last several years community stakeholders and OHA have paid increasing attention to advancing oral health integration, including the appointment of a dental director in 2015 to work across OHA to provide coordination and direction on oral health initiatives and dental health systems transformation work. In addition, CCOs are working on improving oral health at the local level and about half of CCOs have included oral health in their Transformation Plans.

To integrate oral health needs into the PCPCH model, PCPCH staff have proposed the addition of a new standard which will recognize clinics that assess for oral health needs and facilitate access to appropriate treatment. The committee supports this proposal and recommends OHA ensure the measure language remain broad to account for systemic barriers such as distinct insurance plans for health care and dental care, billing for oral health examinations or services within primary care settings, the current lack of EHRs or technology systems that facilitate referral tracking with dental providers and the challenges in achieving sufficient cooperation and

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<sup>28</sup> Oregon Health Authority. (2017). [Oral Health in Oregon's CCOs: A Metrics Report](#).

collaboration from dental providers. In addition, in order to ensure a feasible oral health standard and maintain the value of tracking for serious health concerns, the committee recommends that OHA apply a disease-specific focus to these measures—encouraging clinics to prioritize access for their patients with high oral health needs such as tobacco users, children, pregnant, immunocompromised and those with cancer. The final recommended measures and point values for Standard 3.F are:

## Standard 3.F: Oral Health Services

- 3.F.1 – PCPCH utilizes a screening strategy for oral health needs (5 Points)
- 3.F.2 - PCPCH has a mechanism to track recommendations to dental providers (10 Points)
- 3.F.3 - PCPCH provides integrated oral health services by dental providers (15 Points)

Finally, the committee recommends that OHA convene a Technical Advisory Committee to develop the technical specifications for this standard—suggestions for which include additional guidance around key services such as administering fluoride varnishing, prescribing fluoride and offering First Tooth<sup>29</sup> assessments.

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<sup>29</sup> Oregon Health Authority. (2019) [Oregon First Tooth Project](#).

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# Improving health equity within the PCPCH model

Persons in the U.S. experience significant disparities in life expectancy and other health outcomes based on racial or ethnic group, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geographic location and other characteristics historically linked to discrimination or exclusion. While some of the determinants of health are outside the scope of impact for health care organizations, primary care can play a significant role in addressing disparities at the point of care and can impact many of the determinants that create these disparities.<sup>30</sup>

Ignatius Bau, a nationally-recognized health care policy consultant known for providing resources for equitable and patient-centered care, reviewed Oregon’s PCPCH model and provided recommendations. Suggestions centered around understanding the diversity of patients served, engaging patients (and their families/caregivers) in their own health care, meeting the communication needs of diverse patients, providing team-based care to diverse patients, addressing the social determinants of health and integrating the reduction of disparities into quality improvement and practice transformation. PCPCH Program staff have integrated some of these suggestions into PCPCH Program’s processes and OHA will incorporate them into the next iteration of the PCPCH Recognition Criteria Technical Specifications and Reporting Guide (Technical Assistance Guide). This expert also provided recommendations for the standards and measures which OHA will review and consider when making revisions. The committee discussed some of those recommendations:

**Standard 2.C - Patient and Family Involvement in Quality Improvement:** Replace “patient-defined families” with the word “families” and provide definitions of this and “caregiver” in specifications as inclusive of any party defined and designated by the patient. Include instructions on documenting appropriate Health Insurance Portability and Accountability Act (HIPAA) waivers, powers of attorney and other legal authorizations to share personal health information with such patient-defined and designated family members and caregivers.

**Standard 5.A - Population Data Management:** Clarify that PCPCHs must include their entire patient population in their population data management activities.

**Standard 5.C - Complex Care Coordination:** Include “patient-defined and designated family and caregivers” in 5.C.1 and the word “diverse” in 5.C.2 and 5.C.3—with a list of examples included in the definition of “diverse” in the technical specifications.

**Standard 5.D - Test & Result Tracking:** Include “caregivers” and require an explanation of test results to patients, family or caregivers.

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<sup>30</sup> Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. (2016). [Achieving Health Equity: A Guide for Health Care Organizations](#). IHI White Paper.

**Standard 6.A - Language/Cultural Interpretation:** Change title of this standard to “Meeting Language and Cultural Needs” and revise language in 6.A.1 for clarity.

The committee supports these changes and recommends that OHA distinguish between equality and equity in the TA Guide and provide instructions or explicit examples for PCPCHs in the technical specifications for various standards on how to improve the equity of their processes. The committee acknowledges that OHA may incorporate additional health equity recommendations when determining final revisions to the 2017 standards.

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# PCPCH tier revisions

## 5 STAR designation criteria

The fifth tier in the PCPCH model is a unique designation called “5 STAR.” This designation distinguishes exemplary clinics that have implemented advanced transformative processes into their workflow using the PCPCH model framework and recommended best practices. To be a 5 STAR PCPCH, practices must meet three criteria:

1. Attest to 255 points or more on the clinic’s most recent PCPCH application.
2. Meet at least 11 of 13 advanced PCPCH model measures.
3. Receive a site visit to verify they meet all PCPCH standards they attest to. The designation is not awarded on attestation only.

The 13 model measures in criteria two are a selection of PCPCH measures that span each of the six PCPCH core attributes. A volunteer advisory committee identified these 13 as requiring advanced effort and dedication in primary care.

In response to potential changes and additions to the PCPCH model standards summarized in this report, PCPCH staff have proposed revising the measures included in the 5 STAR menu and expanding the list from 13 to 16. The committee supports this proposal and recommends OHA keep the threshold at 80% – meaning clinics would need to meet 13 out of 16 instead of 11 out of 13 measures. There was some discussion around whether clinics that serve only pediatric patients should have a lower threshold due to the challenges in meeting some of the selected measures, but a staff review of the final proposed 5 STAR menu found all measures to be feasible for pediatric clinics. The final recommended revisions for the 5 STAR menu are included below:

### Recommended additions to 5 STAR menu:

- 1.A.2 – In-Person Access (*see proposed revisions*)
- 1.G.2 – Alternative Access (*newly proposed measure*)
- 2.C.2 – Patient and Family Involvement in Quality Improvement
- 2.E.2 – Ambulatory Sensitive Utilization
- 3.D.3 – Comprehensive Health Assessment & Intervention (*newly proposed measure*)
- 4.G.3 – Medication Reconciliation and Management (*see proposed revisions*)

### Recommended removals from 5 STAR menu:

- 5.C.1 – Responsibility for Care Coordination
- 5.E.2 – Coordination with Specialty Care
- 3.C.2 – Referral Process with Mental Health, Substance Abuse, or Developmental Providers (*see proposed revisions*)

# Tier threshold revisions

PCPCHs attest to meeting measures in the model which are each assigned a point value (0-15). A PCPCH’s overall tier level is determined by the number of points earned. This tiered structure was created to encourage continued health system improvement and to provide a quality improvement framework for PCPCHs. In 2017, the program transitioned from a 3-tiered structure to a 5-tiered structure with the point thresholds shown in Figure 1.

**Figure 1: Current tier point thresholds (2017 PCPCH Standards)**

Tier	Thresholds*	Additional requirements
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65-125 points	+ All must-pass standards
Tier 3	130 – 250 points	+ All must-pass standards
Tier 4	255 - 380 points	+ All must-pass standards
5 STAR	255 – 380 points  <i>*based on current PCPCH model</i>	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

Since the creation of these tier thresholds, clinics have incorporated many of the PCPCH standards into their practices to the extent that the vast majority of PCPCHs are recognized at a Tier 4 or 5 STAR. This skew towards higher tier levels may also be a result of some of the PCPCH standards becoming more feasible and commonplace within Oregon’s health care system due to developments in technology, communication, and the spread of best practices.

If the revisions proposed by the committee in this report are adopted, the total points available to clinics will increase from 380 to 425. The committee therefore recommends OHA increase the point thresholds for each tier level in a way that redistributes the newly available points, continues to encourage improvements in quality and rewards clinics that implement more measures in the PCPCH model.

The committee developed its recommendations shown in Figure 2 with the following considerations:

- PCPCHs should be given sufficient time to re-evaluate their tier level and pursue workflow/policy adjustments before applying under the new 2020 PCPCH standards
- The estimated percentage of PCPCHs that will be impacted should remain reasonable.
- Revisions should consider the challenges that rural clinics face in meeting certain standards.
- The recommended tier point thresholds apply to the 2020 PCPCH standards only.

Figure 2 shows the final recommended point thresholds for each tier.

**Figure 2: New tier point thresholds (2020 Standards)**

<b>Tier</b>	<b>Thresholds*</b>	<b>Additional requirements</b>
Tier 1	60 - 100 points	+ All must-pass standards
Tier 2	105 - 155 points	+ All must-pass standards
Tier 3	160 - 280 points	+ All must-pass standards
Tier 4	285 - 425 points	+ All must-pass standards
5 STAR	310 - 425 points	+ All must-pass standards + Meet 13 out of 16 specified measures + All measures are verified with site visit

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# National Committee for Quality Assurance & Patient-Centered Medical Home alignment

As of October 2019, 32 practices in Oregon are recognized as a [National Committee for Quality Assurance \(NCQA\) Patient Centered Medical Home \(PCMH\)](#). NCQA recognized 13,000 primary care practices nationwide as a NCQA PCMH. While this model is not identical to the Oregon PCPCH model, there are areas of commonality.<sup>31</sup>

Because of this overlap, clinics recognized under the 2011 or 2014 NCQA PCMH criteria currently have the option of either submitting a regular PCPCH application (which is required if they would like to be considered for a Tier 4 or 5 STAR) or an abbreviated PCPCH application attesting to two additional “must pass” measures which are not in the NCQA PCMH criteria:

1. 2.A.0 -PCPCH tracks one quality metric from core or menu set of PCPCH Quality Measures
2. 5.F.0 - PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.

If these criteria are met NCQA PCMH recognized clinics are recognized as a PCPCH at the same tier level that NCQA has certified the clinic. In 2017 NCQA PCMH eliminated their levels (or tiers). Clinics in this program are now either recognized or they are not. Given this change the committee recommends OHA implement the following changes:

- Clinics recognized under the 2011 NCQA PCMH criteria are no longer eligible to submit an abbreviated PCPCH application. No clinics in Oregon are currently recognized under these criteria.
- Clinics recognized under the 2014 NCQA PCMH criteria follow the protocol as described above and will be recognized at the equivalent PCPCH tier level.
- Clinics recognized under the 2017 NCQA PCMH criteria follow the protocol as described above and will be recognized as a Tier 4 PCPCH.
- Clinics recognized under the 2017 NCQA PCMH are required to complete the regular PCPCH application if they would like to apply for 5 STAR designation.

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<sup>31</sup> Oregon Health Authority. (2017). [2017 PCPCH Standards - NCQA PCMH 2017 Standards – Crosswalk](#).

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# Implementation of committee recommendations

Beginning in January 2020, OHA will review the committee recommendations presented in this report along with other stakeholder feedback to determine the final revisions to the PCPCH model and standards which will then be codified in [Oregon Administrative Rule](#) (OAR).

The technical specifications for each of the standards presented in this report—to be included in the next iteration of the PCPCH Recognition Criteria Technical Assistance and Reporting Guide—will be developed in early 2020 by PCPCH staff and be consistent with the recommendations of the committee. Selected committee members and content experts will comprise a Technical Assistance Group (TAG) to help program staff to update and revise selected measures.

OHA will implement the final revised standards and technical specifications in mid-2020 at which point primary care clinics will apply for PCPCH recognition under the revised model.

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# Future areas of focus

To emphasize the importance of continued primary care home practice transformation, the 2012 committee introduced the concept of measures in development as a means to identify aspirational measures that would be ideal but are not uniformly achievable to measure in the current system.<sup>32</sup> Building upon that concept, this committee has identified key areas of focus within the model to serve as the foundation for future model refinements.

## **The 11 must-pass measures**

The committee recommends OHA re-evaluate the 11 must-pass measures when considering future revisions to the model. Suggestions along this line include making the must-pass measures more accessible to alternative forms of practices such as telemedicine clinics and expanding them to include 4.F, 5.D or any measures already met by over 95% of clinics.

## **The role of traditional health workers in Standard 3.D**

While social needs screening tools have the potential to improve patient health and wellbeing, they also run the risk of re-traumatizing patients, worsening mistrust with patients from communities affected most by disparities and putting patients at risk for further harm. To combat these risks, OHA may want to consider encouraging social needs screening and intervening be facilitated by Traditional Health Workers (THWs). In addition to their expertise around empathic inquiry, trauma-informed care and popular education, THWs such as Community Health Workers are well-suited to assist clinics in understanding and addressing the deeper root causes of social needs within their communities.

## **Integrating health literacy**

Low levels of health literacy — or the ability to understand basic health information in order to make appropriate health decisions—have been linked to misuse of medications, higher rates of hospitalization and lower use of preventive services. According to the National Assessment of Adult Literacy, only 12% of U.S. adults have proficient health literacy, with some groups experiencing disproportionately lower rates such as older persons, persons of color, persons with less than a high school degree or General Education Diploma (GED), persons with low income levels, non-native speakers of English and persons with compromised health status.<sup>33</sup> Despite the need to address these trends within primary care, standardized methods for assessing and improving health literacy are limited. The committee therefore recommends OHA consider integrating health literacy into future iterations of the PCPCH model as more tools and evidence-based methods of assessment become available.

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Oregon Health Authority (2013). Standards and Measures for Patient-Centered Primary Care Homes: [Final Report of the Patient-Centered Primary Care Home Standards Advisory Committee of 2012](#).

<sup>33</sup> Oregon Health Authority. (2018). [Oregon's State Health Assessment](#).

## **Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys**

Due to their administrative complexity and lag in feedback, the CAHPS survey tools are considered by some clinics to be less actionable as quality improvement tools than other patient feedback tools. However, the PCPCH program team and committee could not identify an alternative that could offer clinics the same level of guidance, benchmarking and standard method to assess patient experience. The committee therefore recommends that OHA re-evaluate the CAHPS requirements within the PCPCH model during future discussions, particularly if better tools are made available over time.

## **5 STAR PCPCH accountability**

With the intent of the 5 STAR designation being to recognize exemplary clinics, the committee urges OHA to devote additional attention to how exemplary care is defined and measured within the PCPCH Program. OHA may want to consider pursuing an evaluation of the 5 STAR designation to determine differences in quality of care or health outcomes. OHA may also want to consider the extent to which 5 STARS should be held accountable to the overall communities they serve or whether the 5 STAR criteria may be revised in the future to promote population health.



### **HEALTH POLICY AND ANALYTICS**

Patient-Centered Primary Care Home Program

421 SW Oak, Suite 775

Portland, Oregon 97201

Phone: 503-373-7768

Email: [PCPCH@dhsoha.state.or.us](mailto:PCPCH@dhsoha.state.or.us)

You can get this document in other languages, large print, braille or a format you prefer. Contact the PCPCH Program at 503-373-7768 or email [PCPCH@dhsoha.state.or.us](mailto:PCPCH@dhsoha.state.or.us). We accept all relay calls or you can dial 711.

# Appendix A: PCPCH Program vision, mission, and values

## Vision

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

## Mission

The mission of the PCPCH Program is to be a trusted partner in primary care, collaborating with stakeholders to set the standard for transformative, whole-person, and evidence-based care.

## Values

### **Service Excellence**

We respect and quickly respond to the needs of the people, families, and communities as well as our partners and stakeholders. We deliver efficient and effective solutions to meet those needs.

### **Partnership**

In our service to the public we seek out, listen to and collaborate with our partners and stakeholders across diverse communities. Our common goal is to protect and promote all Oregonians' health.

### **Innovation**

All OHA employees are empowered to improve OHA and how we serve the people of Oregon in our quest for better health, better care and lower costs. We find novel solutions to problems, bringing our creativity, experience and openness to the table. We do not accept the status quo if it no longer works to get the job done.

### **Leadership**

Everyone at OHA is a leader. We bring our talent, creativity, compassion, competence, generosity, and stewardship to the work we do every day. Our leadership is founded on innovative strategies and sound management. Each and every one of us is responsible for helping to create a healthy Oregon.

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**Integrity**

We act with integrity in all we do. We are each accountable for maintaining the highest standards in all aspects of our work. We are good stewards of the public trust and the public dollar. Our decisions are informed, fiscally responsible and transparent.

**Health Equity**

We promote health equity so that everyone can reach their full health potential. We honor diverse cultures, histories and health practices. We reflect our communities' diversity as we make decisions about how health resources are developed and distributed. We promote a workplace environment that ensures inclusion and equity.

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# Appendix B: 2019 Standards Advisory Committee Charter

## I. Authority

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Enacted Oregon House Bill (HB) 2009 established the Oregon Health Authority (Authority) and created the Patient-Centered Primary Care Home (PCPCH) program. The goal of the PCPCH program is to improve the availability and affordability of high-quality patient centered primary care to all Oregonians through promotion and development of Oregon's existing primary care infrastructure into Patient-Centered Primary Care Homes.

The PCPCH Standards Advisory Committee (Committee) provides the Authority with policy and technical expertise for the PCPCH model of care. The Committee is convened periodically to review PCPCH implementation progress and advise on refining the model to further guide primary care transformation.

## II. Deliverables

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The Committee will advise the Authority on the following:

1. Revising a specific set of existing standards and measures based upon staff and community experience with the model; and
2. New standards or measures for inclusion in the PCPCH model including but not limited to, oral health, social determinants of health, health equity and substance use disorders.

The Committee will convene monthly from July to December 2019 to discuss what is listed above and will deliver a written report with recommendations to OHA on the revisions to the PCPCH model by January 2020. The Committee's recommendations should be framed by the following guidelines and considerations:

- The committee should incorporate new evidence, where possible, into the model;
- The rigor of the model should increase so that practices are incentivized to continue along in the transformation process for those that have already achieved a 5 STAR status while continuing to support practices currently achieving a Tier 1 status;
- The committee should focus on standards and measures only, recognizing that technical specifications consistent with the recommendations of the committee will be developed;

- The model should minimize the burden of reporting wherever possible, while recognizing that measuring data in a standardized way allows for the model to be replicated and confirmed;
- Standards and measures developed by the committee should be sufficiently broad to be applicable to primary care clinics of different sizes, with different patient populations and in different geographic regions across Oregon;
- Standards and measures should build on existing PCPCH, health system transformation, and quality measurement work in Oregon and seek to be broadly acceptable to all major stakeholders; and
- While the committee will not consider payment reform specifically, standards should be developed with the goal of being used by public and private payers seeking to implement primary care payment reform to support the PCPCH model.

### **III. Dependencies**

The ability of the Committee to fulfill its statutory duties as outlined in sections I and II is contingent upon support of and direction by OHA, as well as coordination with other health policy advisory bodies.

### **IV. Membership**

Per [House Bill 2009](#), H.R. 2009 (enacted), the OHA director shall appoint a minimum of 15 individuals who represent a diverse constituency and are knowledgeable about patient centered primary care home delivery systems and health care quality. The 2019 Committee members represent diverse stakeholder perspectives across primary care, including providers, payers, patients, behavioral health providers, oral health, substance use, traditional health workers, nurses and social determinants of health experts. Members represent all areas of the state, including rural and frontier communities.

# Appendix C: 2019 Standards Advisory Committee Roster

## Co-Chair

Barbara Martin, PA  
Senior Director of Primary Care  
Central City Concern  
Portland, OR

Angie Kuzma, MPH, CHW  
Policy & Data Manager  
Oregon Community Health Workers Association  
Portland, OR

Brandon Lynch, MD, MPH  
Medical Director  
Boulder Care  
Portland, OR

Cindy Klug  
Director, Clinical Innovation & Transformation  
Providence Medical Group  
Portland, OR

David Ross  
Director of Practice Improvement and Transformation  
Comagine Health  
Portland, OR

Elke Geiger Towey  
Program Director, Columbia Gorge CCO  
PacificSource  
Hood River, OR

Heather Whetstone, MD  
Family Physician  
Clackamas County Beaver Creek Health Center  
Oregon City, OR

## Co-Chair

Scott A. Fields, MD, MHA  
Chief Medical Officer  
OCHIN  
Portland, OR

Ben Hoffman, MD  
Professor of Pediatrics, Director of Oregon Center  
for Children and Youth with Special Health Needs  
OHSU  
Portland, OR

Bryant Campbell  
Patient/consumer  
Providence Patient and Family Advisory Council  
Portland, OR

Claire Tranchese  
Policy and Programs Senior Director  
Oregon Primary Care Association  
Portland, OR

Deborah Rumsey  
Executive Director  
Children's Health Alliance  
Portland, OR

Glenn Rodriguez, MD  
Family Physician, retired  
Oregon Academy of Family Physicians  
Portland, OR

Jeanene Smith, MD, MPH  
Principal, Physician  
Health Management Associates  
Portland, OR

Jill Boyd  
Primary Care Transformation Specialist  
GOBHI, Eastern Oregon CCO  
La Grande, OR

Kris Keith  
Administrator  
Brookings Harbor Medical Center & Oak Street Health  
Clinic  
Brookings, OR

Lynnea Lindsey, PhD  
Director, Behavioral Health Services  
Legacy Health  
Portland, OR

Meg Bowen  
Practice Coach  
OCHIN  
Joseph, OR

Millesa Park  
Director of HealthCare Outcomes  
Yakima Valley Farm Workers Clinic  
Toppenish, WA

Sara Crowell  
Practice Enhancement Research Coordinator  
Oregon Rural Practice-based Research Network  
Portland, OR

Tanveer Bokhari, MBBS  
Director of Quality Improvement  
Umpqua Health Alliance  
Roseburg, OR

Julie Foster, FNP  
Executive Chair for the Independent Practice  
Business Owner's Committee  
Oregon Nurses Association  
Portland, OR

Laura McKeane, EFDA  
Oral Health Integration Manager  
AllCare CCO  
Grants Pass, OR

Maeghan Culver, ND  
Board Member  
Oregon Association of Naturopathic Physicians  
Tualatin, OR

Megan Viehman, PharmD  
Pharmacist  
OHSU Richmond  
Portland, OR

Patty Black  
Coordinator for Patient & Family Centered Care  
PeaceHealth  
Eugene, OR

Shilo Tippett, PhD  
Clinical Psychologist  
St. Charles Medical Group - Madras  
Madras, OR

Tamara Harris  
System Pediatric Clinics Manager  
Mosaic Medical  
Bend, OR

# Appendix D: Summary of proposed revisions to the 2017 PCPCH model

The following document summarizes the proposed revisions to the 2017 PCPCH model recommended by the PCPCH Standards Advisory Committee.

Please refer to the following definitions when using this document:

- Unchanged:** This measure was part of the 2017 criteria and language and/or point values have not changed.
- Revised:** This measure was part of the 2017 criteria but proposed changes were made to language and/or point values.
- New:** This measure was not part of the 2017 criteria and is proposed as a new measure to the model.
- (D):** Data submission to OHA required.

The advisory committee recommends that OHA keep the number of must-pass standards at 11 but revise some of them including 2.A.0, 3.B.0, 4.C.0, and 6.C.0. Every recognized clinic would need to meet these must-pass standards. The other standards are optional, allowing clinics to accumulate points towards a total that determines their overall tier of PCPCH recognition. The total points available in the PCPCH model with all proposed changes is 425 points (up from a total of 380 points in the 2017 model).

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>CORE ATTRIBUTE 1: ACCESS TO CARE - <i>“Health care team, be there when we need you.”</i></b>			
<b>Standard 1.A) In-Person Access</b>			
1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams.	Revised <sup>1</sup>	No	5
1.A.2 PCPCH regularly tracks timely access and communication to clinical staff and care teams and has an improvement plan in place to improve their outcomes.	Revised <sup>2</sup>	No	10

<sup>1</sup> All of measure language revised

<sup>2</sup> All of measure language revised

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<del>1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.</del>	<b>Deleted</b>	<del>No</del>	<del>15</del>
<b>Standard 1.B) After Hours Access</b>			
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	Unchanged	No	5
<b>Standard 1.C) Telephone and Electronic Access</b>			
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Unchanged	Yes	0
<b>Standard 1.D) Same Day Access</b>			
1.D.1 PCPCH provides same day appointments.	Unchanged	No	5
<b>Standard 1.E) Electronic Access</b>			
1.E.1 PCPCH provides patients with access to an electronic copy of their health information.	<b>Revised<sup>3</sup></b>	No	5
<b>Standard 1.F) Prescription Refills</b>			
1.F.2 PCPCH tracks the time to completion for prescription refills.	Unchanged	No	10
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	Unchanged	No	15
<b>Standard 1.G) Alternative Access</b>			
1.G.1 PCPCH regularly offers patient portal messaging, and identifies patient populations that would benefit from additional alternative appointment types.	<b>New</b>	No	5
1.G.2 PCPCH regularly offers at least one alternative to traditional office visits that meet the needs of their patient population and increases access to clinical staff and care teams.	<b>New</b>	No	10

<sup>3</sup> Some of measure language revised

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>CORE ATTRIBUTE 2: ACCOUNTABILITY - "Take responsibility for making sure we receive the best possible health care."</b>			
<b>Standard 2.A) Performance &amp; Clinical Quality</b> (check all that apply) <sup>4</sup>			
2.A.0 PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures. (D)	Revised <sup>5</sup>	Yes	0
2.A.1 PCPCH engages in a Value-Based Payment arrangement with payers covering a significant portion of the clinic population that includes three measures from the set of PCPCH Quality Measures.	Revised <sup>6</sup>	No	5
<del>2.A.2 PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures (D)</del>	<del>Deleted</del>	<del>No</del>	<del>10</del>
2.A.3 PCPCH tracks, reports to the OHA, and demonstrates a combination of improvement and meeting benchmarks on three of the PCPCH Quality Measures. (D)	Revised <sup>7</sup>	No	15
<b>Standard 2.B) Public Reporting</b>			
2.B.1 PCPCH participates in a public reporting program for performance indicators and data collected for public reporting programs is shared with providers and staff within the PCPCH.	Revised <sup>8</sup>	No	5
<del>2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.</del>	<del>Deleted</del>	<del>No</del>	<del>10</del>
<b>Standard 2.C) Patient and Family Involvement in Quality Improvement</b>			
2.C.1 PCPCH involves patients, family, and caregivers as advisors on at least one quality or safety initiative per year.	Revised <sup>9</sup>	No	5

<sup>4</sup> Now check all that apply (previously wasn't)

<sup>5</sup> Some of the measure language revised; language in bold

<sup>6</sup> All of measure language revised

<sup>7</sup> Some of the measure language revised; language in bold

<sup>8</sup> Language in bold added to measure

<sup>9</sup> Some of the measure language revised; language in bold

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
2.C.2 PCPCH has established a formal mechanism to integrate <b>patient, family, and caregiver advisors</b> as key members of quality, safety, program development and/or educational improvement activities.	Revised <sup>10</sup>	No	10
2.C.3 <b>Patient, family, and caregiver advisors</b> are integrated into the PCPCH and function in peer support or in training roles.	Revised <sup>11</sup>	No	15
<b>Standard 2.D) Quality Improvement</b>			
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	Unchanged	No	5
2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	Unchanged	No	10
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	Unchanged	No	15
<b>Standard 2.E) Ambulatory Sensitive Utilization (check all that apply) <sup>12</sup></b>			
2.E.1- <b>PCPCH engages in a Value-Based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure.</b>	Revised <sup>13</sup>	No	5

<sup>10</sup> Some of the measure language revised; language in bold

<sup>11</sup> Some of the measure language revised; language in bold

<sup>12</sup> Now check all that apply (previously wasn't)

<sup>13</sup> All of measure language revised

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
2.E.2 - <b>PCPCH identifies patients with unplanned or adverse utilization patterns for at least one selected utilization measure and contacts patients, families and caregivers for follow-up care if needed, within an appropriate period of time.</b>	Revised <sup>14</sup>	No	10
2.E.3 - PCPCH tracks <b>at least one</b> selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	Revised <sup>15</sup>	No	15
<b>Standard 2.F) PCPCH Staff Vitality</b>			
2.F.1- <b>PCPCH uses a structured process to identify opportunities to improve the vitality of their staff.</b>	New	No	5
2.F.2 - <b>PCPCH develops, implements and evaluates a strategy to improve the vitality of their staff.</b>	New	No	10
<b>CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - "Provide or help us get the health care, information, and services we need."</b>			
<b>Standard 3.A) Preventive Services</b>			
3.A.1 PCPCH routinely offers or coordinates recommended preventive services appropriate for your population (i.e. age and gender) based on best available evidence and identifies areas for improvement.	Unchanged	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population.	Unchanged	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	Unchanged	No	15

<sup>14</sup> All of measure language revised

<sup>15</sup> Some of the measure language revised; language in bold

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>Standard 3.B) Medical Services</b>			
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services <b>including recommended immunizations</b> ; Patient education and self-management support.	Revised <sup>16</sup>	Yes	0
<b>Standard 3.C) Mental Health, Substance Abuse, &amp; Developmental Services (check all that apply)</b>			
3.C.0 PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site, local referral resources and processes.	Unchanged	Yes	0
3.C.2.a <b>PCPCH collaborates and coordinates care or is co-located with one of the following: specialty mental health, substance abuse disorders, or developmental providers; and provides co-management as needed.</b>	Revised <sup>17</sup>	No	10
3.C.2.b <b>PCPCH provides onsite pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referral to recovery support.</b>	New	No	10
3.C.3 PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.	Unchanged	No	15
<b>Standard 3.D) Comprehensive Health Assessment &amp; Intervention</b>			
3.D.1 PCPCH has a routine assessment to identify health-related social needs in their patient population.	Revised <sup>18</sup>	No	5
3.D.2 PCPCH tracks referrals to outside community-based agencies or referrals to care coordination within the PCPCH.	New	No	10

<sup>16</sup> Language in bold added to measure

<sup>17</sup> All of measure language revised

<sup>18</sup> All of measure language revised

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
3.D.3 PCPCH describes and demonstrates its process for health-related social needs risk factor interventions and coordination of resources for patients with health-related social needs.	New	No	15
<b>Standard 3.E) Preventive Services Reminders</b>			
<del>3.E.1 PCPCH sends reminders to patients for preventative/follow-up care using a method that satisfies either Stage 1 or Stage 2 meaningful use measures.</del>	<del>Deleted</del>	<del>No</del>	<del>5</del>
3.E.2 PCPCH uses patient information, clinical data and evidence-based guidance to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders.	Unchanged	No	10
3.E.3 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services.	Unchanged	No	15
<b>Standard 3.F) Oral Health Services</b>			
3.F.1 PCPCH utilizes a screening strategy for oral health needs.	New	No	5
3.F.2 PCPCH has a mechanism to track recommendations to dental providers.	New	No	10
3.F.3 PCPCH provides integrated oral health services by dental providers.	New	No	15
<b>CORE ATTRIBUTE 4: CONTINUITY - "Be our partner over time in caring for us."</b>			
<b>Standard 4.A) Personal Clinician Assigned</b>			
4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	No	15

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>Standard 4.B) Personal Clinician Continuity</b>			
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Unchanged	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	10
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	15
<b>Standard 4.C) Organization of Clinical Information</b>			
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the Centers for Medicare and Medicaid Services and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this EHR as needed at each visit.	Revised <sup>19</sup>	Yes	0
<b>Standard 4.D) Clinical Information Exchange</b>			
4.D.2 PCPCH exchanges clinical information electronically to another provider or setting of care.	New	No	10
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	Unchanged	No	15
<b>Standard 4.E) Specialized Care Setting Transitions</b>			
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Unchanged	Yes	0
<b>Standard 4.F) Planning for Continuity</b>			
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	Unchanged	No	5

<sup>19</sup> All of measure language revised

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>Standard 4.G) Medication Reconciliation and Management</b>			
4.G.1. <del>Upon receipt of a patient from another setting of care or provider of care (transitions of care), the PCPCH performs medication reconciliation using a method that satisfies either Stage 1 or Stage 2 meaningful use measures.</del>	<b>Deleted</b>	No	5
4.G.2 <b>PCPCH has a process for medication reconciliation for patients with complex or high-risk medication concerns.</b>	<b>Revised</b> <sup>20</sup>	No	10
4.G.3 <b>PCPCH provides Medication Management for patients with complex or high-risk medication concerns.</b>	<b>Revised</b> <sup>21</sup>	No	15
<b>CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - “Help us navigate the health care system to get the care we need in a safe and timely way.”</b>			
<b>Standard 5.A) Population Data Management (check all that apply)</b>			
5.A.1 PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its <b>entire</b> patient population, including the identification of sub-populations.	<b>Revised</b> <sup>22</sup>	No	5
5.A.2 PCPCH demonstrates the ability to stratify <b>its entire</b> population according to health risk such as special health care needs or health behavior.	<b>Revised</b> <sup>23</sup>	No	10
<b>Standard 5.B) Electronic Health Record</b>			
5.B.3 <del>PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be “meaningful users” of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.</del>	<b>Deleted</b> <sup>24</sup>	No	15

<sup>20</sup> All of measure language revised

<sup>21</sup> All of measure language revised

<sup>22</sup> Language in bold added to measure

<sup>23</sup> Language in bold added to measure

<sup>24</sup> Language incorporated into measure 4.C.0

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>Standard 5.C) Complex Care Coordination</b> (check all that apply)			
5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients, and tells each patient <b>(and patient-defined and designated family and caregivers)</b> or family the name of the team member(s) responsible for coordinating his or her care.	Revised <sup>25</sup>	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of <b>diverse</b> patients with complex care needs.	Revised <sup>26</sup>	No	10
5.C.3 <b>PCPCH collaborates with diverse patients, families or caregivers to develop individualized written care plans for complex medical or social concerns.</b>	Revised <sup>27</sup>	No	15
<b>Standard 5.D) Test &amp; Result Tracking</b>			
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures <b>timely, confidential notification and explanation of results to patients, family, or caregivers</b> , as well as to ordering clinicians.	Revised <sup>28</sup>	No	5
<b>Standard 5.E) Referral &amp; Specialty Care Coordination</b> (check all that apply)			
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	Unchanged	No	5
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in <b>one or more of the following</b> specialized settings: <b>foster care (either adult or child)</b> , hospital, SNF, long term care facility, <b>SBHC, behavioral health providers and organizations.</b>	Revised <sup>29</sup>	No	10

<sup>25</sup> Language in bold added to measure

<sup>26</sup> Language in bold added to measure

<sup>27</sup> All of measure language revised

<sup>28</sup> Some of the measure language revised; language in bold

<sup>29</sup> Language in bold added to measure

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH <b>in one or more of the following:</b> dental, educational, social service, foster care, public health, <b>traditional health workers, behavioral health providers and organizations,</b> and pharmacy services.	Revised <sup>30</sup>	No	15
<b>Standard 5.F) End of Life Planning</b>			
5.F.0 PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.	Unchanged	Yes	0
5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients' opt out).	Unchanged	No	5
<b>CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - "Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."</b>			
<b>Standard 6.A) Meeting Language and Cultural Needs<sup>31</sup></b>			
6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.	Unchanged	Yes	0
6.A.1 PCPCH <b>provides</b> written patient materials <b>in non-English languages</b> spoken by <b>populations served at the clinic.</b>	Revised <sup>32</sup>	No	5
<b>Standard 6.B) Education &amp; Self-Management Support</b>			
6.B.1 PCPCH <b>provides</b> patient-specific educational resources <b>to their patient population.</b>	Revised <sup>33</sup>	No	5

<sup>30</sup> Some of the measure language revised; language in bold

<sup>31</sup> Standard previously called "Language/Cultural Interpretation"

<sup>32</sup> Some of the measure language revised; language in bold

<sup>33</sup> Some of the measure language revised; language in bold

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
6.B.2 PCPCH provides patient specific education resources and offers self-management support resources to their patient population.	Revised <sup>34</sup>	No	10
6.B.3 PCPCH providers patient specific education resources, offers self-management support resources to their patient population, and tracks utilization of multiple self-management groups.	Revised <sup>35</sup>	No	15
<b>Standard 6.C) Experience of Care</b>			
6.C.0 PCPCH surveys a sample of its patients and families <del>at least at least every two years on their experience of care.</del> The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. <del>The recommended patient experience of care survey is one of the CAHPS survey tools.</del>	Revised <sup>36</sup>	Yes	0
6.C.1 PCPCH surveys a sample of its patients and families on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The clinic has a survey planning strategy in place and shares data with clinic staff.	New	No	5
6.C.2 – PCPCH surveys a sample of its population <del>at least every two years</del> on their experience of care using of one of the CAHPS survey tools, <b>has a survey planning strategy</b> , and demonstrates the utilization of survey data in quality improvement process.	Revised <sup>37</sup>	No	10
6.C.3 - PCPCH surveys a sample of its population <del>at least every two years</del> on their experience of care using of one of the CAHPS survey tools, <b>meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy</b> , and demonstrates the utilization of survey data in quality improvement process.	Revised <sup>38</sup>	No	15

<sup>34</sup> All of measure language revised

<sup>35</sup> All of measure language revised

<sup>36</sup> Measure language condensed

<sup>37</sup> Some of the measure language revised; language in bold

<sup>38</sup> Some of the measure language revised; language in bold

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
<b>Standard 6.D) Communication of Rights, Roles, and Responsibilities</b>			
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	Unchanged	No	5