Oregon Health Authority | PATIENT CENTERED PRIMARY CARE HOME PROGRAM

PCPCH Standards Advisory Committee Report

April 2023

Contents

This publication was prepared by the Oregon Health Authority's Patient-Centered Primary Care Home Program.

For questions about this report, please contact:

PCPCH Program
421 SW Oak Street, Suite 775
Portland, Oregon 97201
Phone: 503-373-7768
Email: PCPCH@oha.oregon.gov

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 interested persons 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, 2015, and 2019 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation.

OHA reconvened the Committee again from August 2022 to February 2023 to develop recommendations on:

1. Application of OHA's health equity definition and 10-year strategic goal to eliminate health inequities throughout PCPCH model and standards based on community feedback gathered during the Program's 2021 Health Equity Initiative[1]
2. Revisions to the existing standards and measures based on staff and community experience with the model
3. Integration of new standards and measures related to health equity, culturally and linguistically appropriate care, and health care cost navigation
4. Revisions to the tier level thresholds and special designations

The Committee's recommendations on these items are included in this report. Among the proposed changes are:

- Strengthening the existing standards and measures
- Adding three new standards
- Replacing of the 5 STAR designation with a point-based Tier 5
- Redistributing the total available points across five tiers
- Adding an Equity STAR designation
- Convening technical advisory groups to provide input on model revisions and Equity STAR designation

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,

[1] Oregon Health Authority (2021). PCPCH Program Health Equity Initiative Report.

and improve the effectiveness of the standards and measures overall. In addition to supporting OHA-s 10-year equity goal, the inclusion of revisions related to culturally and linguistically appropriate care, addressing health inequities, and health care cost navigation are in response to needs identified by community partners and interested persons across Oregon, and Oregon's top state priorities for health system transformation efforts such as CCO 2.0.[2]

These recommendations will inform the next iteration of the PCPCH recognition criteria which will be implemented in 2024. OHA will determine final revisions to the PCPCH model with consideration of the recommendations presented in this report, additional community feedback, alignment with state priorities including eliminating health inequities, and national efforts to transform primary care. The PCPCH Program expects the revised standards to be implemented in the second half of 2024.

[2] Oregon Health Authority. (2018). CCO 2.0 Recommendations of the Oregon Health Policy Board.

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.[3] 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 Home (PCPCH) Program within OHA.

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

In 2009, the OHA Director appointed the first 15-member PCPCH Standards Advisory Committee (Committee) to help OHA develop strategies to identify and evaluate primary care homes. The Committee was made up of diverse community partners and interested persons from Oregon 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 PCPCHs
- 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.

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

[3] Oregon Health Fund Board. (2008). Delivery Systems Committee Recommendations: Report to the Oregon Health Fund Board.

4. Continuity
5. Coordination and integration
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, 2015, 2019 and, most recently, in 2022 to review PCPCH implementation progress and to refine the model to further guide primary care delivery transformation.[4] 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 receiving 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. In 2021, 90.5% of CCO members received primary care at a recognized PCPCH.[5]

Report overview

OHA reconvened the Committee in 2022 to aid with model refinement as it continues to work towards achieving health equity and health care delivery system transformation. This report contains the 2022 Committee's recommended revisions to PCPCH standards, measures, and overall model. This report also includes recommendations for new standards around value-based payments (VBPs), health care cost navigation, and culturally and linguistically appropriate care.

[4] 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.
[5] 2021 CCO Metrics Dashboard

Advancing equity in the PCPCH Program

The COVID-19 pandemic highlighted that the current primary care system does not meet the needs of all people living in Oregon. In December 2020, OHA leadership initiated a process to ensure the PCPCH Program supports a primary care system that addresses community-identified needs, especially the needs of those who experience systemic racism, barriers in accessing care, and health inequities. The PCPCH Program staff embraced this directive, calling it the PCPCH Program Health Equity Initiative (the Initiative).

The Initiative supports OHA's goal of eliminating health inequities by 2030 and is guided by the agency's definition of health equity:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices.*

In 2021, the PCPCH Program convened a Primary Care Health Equity workgroup (PCHE) comprised of OHA staff from across divisions to assist the PCPCH Program in gathering and synthesizing community input about primary care. In partnership with the PCHE, Program staff gathered community input by conducting a literature review to identify existing feedback, listening sessions with over 25 community-based organizations and primary care practices that serve a diverse patient population statewide, and an analysis of data reports and dashboards. Organizations that participated in listening sessions include the Urban League of Portland, Asian Pacific American Network of Oregon, Basic Rights Oregon, Yakima Valley Farm Workers Clinic, Central City Concern, and Winding Waters Medical Clinic, among others.

The PCPCH Program published a report describing the community input process, a summary of the findings and the next steps in the Initiative. PCPCH Program staff presented the report findings to the 2022 Committee to inform and guide the Committee's work as it reviewed and revised the PCPCH standards and measures.

Health equity consultant recommendations

PCPCH Program staff consulted with health equity and policy expert Ignatius Bau, JD throughout the Committee's 2022 convening to ensure alignment with national best practices for equity-centered primary care. Mr. Bau provided suggestions for specific standards as well as guidance around improving health equity and promoting culturally and linguistically appropriate care throughout the model. Final implementation recommendations are as follows:

1. Develop an updated patient-facing fact sheet highlighting some of the revised standards and the benefits of choosing a PCPCH as a provider for diverse patients; make the fact sheet available in Spanish, large print, and as an audio file

2. Continue to partner with primary care and medical associations such as Oregon Primary Care Association, Oregon Medical Association, independent practice associations, and local medical societies, to inform and update their members about the revised standards specifically and the benefits of PCPCH recognition generally

3. Present revised standards to relevant committees including the Heath Equity Committee, Oregon Council of Health Care Interpreters, Traditional Health Worker Commission, Health Care Workforce Committee, etc.

4. Continue to encourage payers to collaborate and optimize continuing medical education, technical assistance, practice coaching, and other supports and incentives for PCPCHs in their local area or region

5. Continue to highlight ways in which the PCPCH Program and revised standards align with other statewide initiatives and priorities, including requirements for CCOs, Oregon VBP Compact, etc.

PCPCH Standards Advisory Committee 2022

Scope of work

The Committee's scope of work was informed by feedback received during the Program's community listening sessions[6] and OHA's commitment to ensure that the PCPCH Program supports a primary care system that is equitable for all. Specifically, OHA tasked the Committee with developing recommendations on the following:

1. Revisions to a specific set of existing standards and measures based upon staff and community experience with the model
2. New standards or measures related to health equity for inclusion in the PCPCH model
3. Model revisions such as must-pass measures, special designations, and tier point thresholds

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

In preparation for the Committee meetings, PCPCH Program staff drafted potential revisions to the 2020 PCPCH model and standards, as well as new measures for the Committee to consider. These proposed revisions were informed by:

- Information shared with the PCPCH Program during its 2021 community listening sessions
- Guidance from health equity and policy expert Ignatius Bau and PCPCH Program clinical advisor Dr. Jeanene Smith
- A literature review of available evidence
- A review of the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) standards
- Feedback from community partners, providers and clinics, and other interested persons in Oregon
- Information gathered by Program staff during PCPCH site visits

Key guidelines and considerations

In addition to the specific language in HB 2009, OHA required the 2022 Committee to frame its work based on the following guidelines and considerations:

- The Committee should incorporate new evidence, where possible, into the model.
- The Committee should focus on reducing health inequities, where possible, into the model and align with OHA's strategic goal of eliminating health inequities by 2030.
- The Committee should assess clinical and social conditions, as well as the historical and contemporary injustices that undermine health, when considering revisions to the measures and standards in the model.

[6] 2021 PCPCH Program Health Equity Initiative Report

- 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 Tier 5 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 by Program staff.
- The model should minimize the burden of reporting wherever possible, while recognizing that measuring data in a standardized away 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 equity, health system transformation, and quality measurement work in Oregon and seek to be broadly acceptable to all impacted communities.
- 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

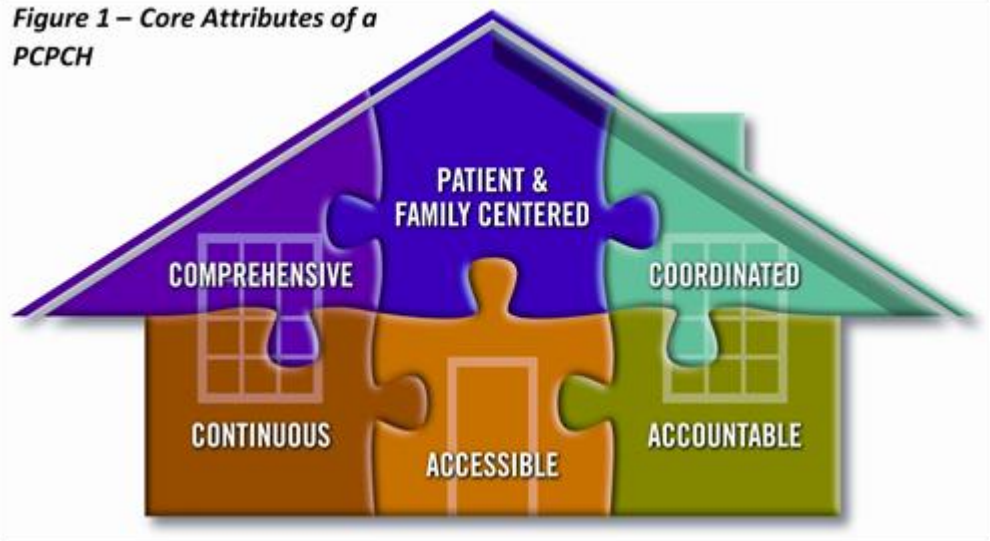
Sixty people applied to be appointed to the Committee. Applicants included people on past Committee rosters, representatives from community-based organizations that participated in listening engagements, providers, primary care content experts and patients. OHA Director Pat Allen appointed the 2022 Committee members based on their knowledge of Oregon's primary care delivery system, commitment to advancing health equity and lived experience with systemic racism and health inequities. Please see Appendix C for a list of Committee members. The Committee met nine times from August 2022 until February 2023. The meetings were facilitated by Erin Campbell from Bailit Health.

OHA will also be convening several technical advisory groups (TAGs) in 2023 to provide input on the recommended revisions to select standards, measures, and the newly proposed Equity STAR designation. Each TAG will include subject-matter experts that can provide additional guidance around specific standards or health system areas. OHA will select TAG members from the 2022 Committee roster, 2022 Committee applicants, and from relevant OHA departments.

Patient-Centered Primary Care Home 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.

Figure 1 – Core Attributes of a PCPCH



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. Except for 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, 637 clinics across the state have been recognized as a PCPCH.

Revisions to existing standards

The following is an overview of the PCPCH standards that the Committee discussed. Each section includes the standard and measures as they are currently written under the 2020 PCPCH Recognition Criteria followed by a summary of the Committee's discussion and ultimate recommendations for that standard. Appendix D provides an overview of how each of these standards and measures might be written if the Committee's recommendations are applied.

Standard 1.A: In-Person Access

> **Current measures (progressive):**
>
> **1.A.1** – PCPCH regularly tracks timely access and communication to clinical staff and care teams. (5 points)
>
> **1.A.2** – PCPCH regularly tracks timely access and communication to clinical staff and care teams, and has an improvement plan in place to improve their outcomes. (10 points)

To meet this standard as it is currently written, PCPCHs may select their own metrics and targets related to timely access and communication. To encourage consistency and improve equity for patients across Oregon, the Committee recommends requiring PCPCHs to select metrics and targets from a standard list to be developed with a technical advisory group (TAG). The final list of options should include additional relevant metrics, align with existing programs and requirements, include metrics relevant to all types of primary care practices (e.g., pediatrics), and consider how the targets chosen for each category will influence patients' preferred modes of communication. In leu of stricter targets, the Committee also recommends allowing PCPCHs to meet measure 1.A.2 if they are either meeting these targets or showing improvement. Additional suggestions include updating the title of the standard to "Timely Access and Communication" and encouraging practices to be mindful of their performance in all timely access and communication categories.

Standard 1.C: Telephone & Electronic Access

> **Current measure (must-pass):**
>
> **1.C.0** – PCPCH provides continuous access to clinical advice by telephone.

The PCPCH Program heard repeatedly during its 2021 community listening sessions that sufficient interpretation services are lacking within primary care in Oregon. The Committee therefore recommends adding an optional 5-point measure to this standard that encourages practices to extend their interpretation services to patients calling in for clinical advice during and after opening hours. There was some debate around whether to include additional measures related to tracking requests

and utilization of translation services, though it was noted that this can be administratively difficult and that any new measures should consider practices that do not often receive requests for these services. Additional suggestions include removing "electronic" from the title of the standard; clarifying expectations for interpreter credentialing; encouraging practices to consider the quality of interpretation services when evaluating contracts; and exploring the translation resources available for practices with limited resources or those that contract with private payers.

Standard 1.E: Electronic Access

Current measure:

1.E.1 – PCPCH provides patients with access to an electronic copy of their health information. (5 points)

PCPCH Program staff heard repeatedly during the Program's 2021 community listening sessions that sufficient interpretation services and accommodations for people with disabilities are lacking within primary care in Oregon. To address these gaps, the Committee recommends incorporating new expectations into this measure around providing electronic health information in a way that is accessible to patients with disabilities, reading limitations, or whose primary language is not English — and increasing the point value to account for these additional expectations. Given the limitations and variety in EHR options for language and disability accessibility, administrative barriers, and the resulting delays in care that can occur, the Committee also recommends that this measure allow for flexibility in how practices meet the accessibility needs of their patients. Finally, the Committee recommends moving the current Measure 1.G.1 concerning patient portal communications into this standard and making it "check all that apply" (see next section for measure language and additional recommendations for Standard 1.G).

Standard 1.G: Alternative Access

Current measures (check all that apply):

1.G.1 – PCPCH regularly communicates with patients through a patient portal. (5 points)

1.G.2 – PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one. (10 points)

As a result of system-wide changes implemented during COVID-19, telehealth has become a common alternative visit type that practices throughout the state offer and more than 99% of PCPCHs are using it to meet 1.G.2. The Committee recommends parsing out telehealth into its own 5-point measure (replacing the current 1.G.1 which would move to Standard 1.E) to continue to promote its value, while reserving 1.G.2 for some of the other alternative visit types that can also improve access for patients.

To address community-identified barriers to culturally appropriate and accessible care, the new measure should require PCPCHs to provide interpreters for telehealth services when needed.

Community partners have also identified barriers patients experience when receiving care in clinic settings and have suggested that primary care practices seek out opportunities to provide services in non-clinic community settings such as local organizations, food banks, or cultural events. The Committee therefore recommends adding a new 15-point measure to this standard recognizing PCPCHs that provide care in community settings on a regular basis. A TAG should be convened to ensure that the measure is flexible, determine which types of care activities and frequencies are in scope, and consider limitations related to billing/reimbursement, malpractice insurance, and metric/reporting requirements.

Standard 2.A: Performance & Clinical Quality

Current measures (check all that apply):

2.A.0 – PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures. (must-pass)

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

2.A.3 – PCPCH tracks, reports to the OHA, and demonstrates a combination of improvement and meeting benchmarks on three of the PCPCH Quality Measures. (15 points)

The PCPCH Quality Measure set is only updated once every three to four years when the Committee is convened to revise the PCPCH standards. This creates barriers for PCPCHs that are tracking metrics more relevant to their patient population or using updated measure specifications from other programs. The Committee therefore recommends allowing PCPCHs to select their own quality measures from Program-designated sources such as the OHA CCO Metrics and the Centers for Medicare & Medicaid Services (CMS) core set of Adult and Child Health Care Quality Measures. There was some debate as to whether the PCPCH Program should promote or only accept specific measures from these sources, with general agreement that Program-designated sources include publicly available benchmarks and measures relevant to all types of practices.

Due to the well-documented inequities in health care utilization and outcomes among different demographic groups and recent national efforts to stratify quality measures accordingly,[7] the Committee also recommends adding two new optional measures to this standard (5 and 15 points) to encourage PCPCHs to identify and reduce disparities in quality measure performance based on race, ethnicity, age, language, or other selected demographic categories. Specifications should be flexible

[7] In California, the state's insurance marketplace (Covered California) and the state's Medicaid Program (Medi-Cal) are both stratifying their quality measures by race and ethnicity.

regarding improvement activities or thresholds, promote alignment with NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) measures when possible, and be developed with a TAG. Finally, to accommodate these new measures the Committee recommends reducing the point value of the current 2.A.3 by 5 points and removing the current 2.A.1 concerning VBP arrangements from this standard (see New Standards section of this report for recommendations around a distinct Value-Based Payment standard on page 25).

Standard 2.E: Ambulatory Sensitive Utilization

Current measures (check all that apply):

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

2.E.2 – PCPCH identifies patients with unplanned or adverse utilization patterns for at least one selected utilization measure and contacts patients, families or caregivers for follow-up care if needed, within an appropriate period of time. (10 points)

2.E.3 – PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure. (15 points)

The PCPCH Utilization Measures set is updated only once every three to four years when the Committee is convened to revise the PCPCH Standards. This creates barriers for PCPCHs that are tracking metrics more relevant to their patient population or using updated measure specifications from other programs. The Committee therefore recommends allowing PCPCHs to select their own utilization measures from Program-designated sources such as the OHA CCO Metrics and the Centers for Medicare & Medicaid Services (CMS) core set of Adult and Child Health Care Quality Measures. A TAG should be convened to identify sources that include measures relevant to patients across the full lifespan and define "utilization measures" in a way that clearly distinguishes them from the quality measures relevant to Standard 2.A.

PCPCHs have also expressed significant challenges in meeting current measure 2.E.3 due to barriers around obtaining utilization data from payers or large health systems in a timely manner. The Committee therefore recommends removing measure 2.E.3 from this standard and replacing it with a new 15-point measure that focuses on following up with patients identified as experiencing disparities in utilization patterns. Disparities in health care utilization and outcomes among different demographic groups are well-documented and there have been recent national efforts to stratify utilization measures accordingly.[8] Finally, the Committee recommends updating the title of this standard and removing the current 2.E.1 concerning VBP arrangements (see New Standards section of this report for recommendations around a distinct Value-Based Payment standard on page 25).

[8] Beginning in 2022, the NCQA is requiring health plans to stratify a specific set of HEDIS measures by race and ethnicity.

Standard 3.C: Behavioral Health Services

Current measures (check all that apply):

3.C.0 – PCPCH has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes. (must-pass)

3.C.1 – PCPCH collaborates and coordinates care or is co-located with specialty mental health, substance use disorders, and developmental providers. PCPCH also provides co-management based on its patient population needs. (5 points)

3.C.2 – PCPCH provides onsite pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals. (10 points)

3.C.3 – PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers. (15 points)

During the COVID-19 pandemic, there was a marked increase in the number of primary care practices offering behavioral health care through telehealth due to workforce shortages and recent improvements in technological access, quality, and payment for telehealth services. The Committee considered whether PCPCHs should be able to meet measure 3.C.3 if they only provide behavioral health care through telehealth. Given the limitations some patients face in accessing telehealth and the reduction in quality of care for certain conditions, the Committee concluded that PCPCHs attesting to 3.C.3 should still be required to ensure that their patients have access to onsite behavioral health options.

The Committee does, however, recommend removing the onsite requirement from measure 3.C.2 to promote telehealth pharmacotherapy in lieu of current workforce shortages and Oregon's opioid crisis. The Committee also recommends leveraging this standard to improve the cultural responsiveness of behavioral health care in Oregon, such as adding language about gender-affirming care, culturally responsive referrals, and promoting both telehealth and in-person services based on condition or patient preference. Finally, the Committee recommends revising the measures in this standard for clarity and adopting the 2019 Committee recommendation to make the current 3.C.1 and 3.C.2 worth the same number of points.

Standard 3.D: Comprehensive Health Assessment & Intervention

Current measures (progressive):

3.D.1 – PCPCH has a routine assessment to identify health-related social needs in its patient population. (5 points)

3.D.2 – PCPCH tracks referrals to community-based agencies for patients with health-related social needs. (10 points)

3.D.3 – PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs. (15 points)

Beginning 2023, a CCO incentive measure was launched that will require CCOs to screen their members for housing, food and transportation insecurity, as well as partner with local community-based organizations to provide interventions for these three health-related social needs (HRSN).[9] To align with these requirements and encourage continuous improvement within the PCPCH model, the Committee recommends requiring PCPCHs that attest to Standard 3.D screen their patients for at least these same three HRSN. The Committee also recommends combining 3.D.1 and 3.D.2 into one 10-point measure that would require PCPCHs to refer patients with positive screens to relevant community-based organizations. The referral tracking requirement would be moved from 3.D.2 into 3.D.3 as one of the more robust interventions that PCPCHs could use to address at least one HRSN; other options are partnering with a community-based organization or providing an intervention at the practice. Additional recommendations include making this standard "check all that apply," updating the title to "Health-Related Social Needs," and encouraging practices to screen in a trauma-informed way or partner with other organizations to reduce over-screening.

Standard 3.E: Preventive Services Reminders

Current measures (progressive):

3.E.2 – PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders. (10 points)

3.E.3 – PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services. (15 points)

[9] Coordinated Care Organization (CCO) Incentive Metrics Social Needs Screening and Referral Measure

PCPCH Program staff heard repeatedly during the Program's 2021 community listening sessions about the need for improved health literacy and culturally responsive care. There is evidence that tailored preventive service reminders can improve screening rates among various groups.[10] With this in mind, the Committee recommends reducing the point values of 3.E.2 and 3.E.3 to allow for a new 15-point measure that requires PCPCHs to identify patients experiencing disparities in preventive services and develop an alternative reminder or outreach strategy for them. This process-oriented measure would complement the outcome measure recommended for Standard 2.A (2.A.3) and could apply to demographic-based groups or patients with low health literacy levels. The Committee also recommends updating all measures in this standard to reflect contemporary tracking procedures and to encourage PCPCHs to improve the general health literacy and cultural responsiveness of their preventive service reminders.

Standard 4.A: Personal Clinician Assigned and Standard 4.B: Personal Clinician Continuity

Current measures in Standard 4.A (progressive):

4.A.0 – PCPCH reports the percent of active patients assigned to a personal clinician or team. (must-pass)

4.A.3 – PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team. (15 points)

Current measures in Standard 4.B (progressive):

4.B.0 – PCPCH reports the percent of patient visits with assigned clinician or team. (must-pass)

4.B.2 – PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (10 Points)

4.B.3 – PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (15 Points)

As primary care has transformed over time, it has become standard practice to assign patients to clinicians or teams. Given that 4.A.3 is no longer as robust as other 15-point measures in the model, the Committee recommends removing this measure and merging Standards 4.A and 4.B into one comprehensive standard: *Clinician or Team Assignment & Continuity*. In this new standard the must-pass measure will combine the current 4.A.0 and the current 4.B.0. In addition, the Committee recommends that the must-pass measure include a process for considering patient choice, need, background, or interest in assignment — as community partners have stressed the importance of

[10] Journal of Medical Systems (2019), Population Health Management (2022), Journal of General Internal Medicine (2021), American Journal of Public Health (1995)

matching patients with providers who can deliver the most culturally appropriate care, as well as the importance of allowing patients to select or change providers. The Committee also recommends convening a TAG to define improvement in the new 4.A.2 (currently 4.B.2), develop the benchmarking process for the new 4.A.3 (currently 4.B.3), determine which appointment types or provider types should be included in continuity calculations, and consider how to account for patients that prefer timeliness of care over continuity.

Standard 4.C: Organization of Clinical Information

Current measure (must-pass):

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; PCPCH updates this EHR as needed at each visit.

In 2021 the Oregon legislature passed house bill (HB) 3159 which directs OHA to create a robust, secure, and efficient system of data collection, storage and reporting for Race, Ethnicity, Language, Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data to support OHA's vision of eliminating health inequities by 2030.

OHA plans to have this new system active no sooner than late 2024. Once this system is active:

- Providers and insurers will need to submit REALD and SOGI data at least annually regardless of the type of encounter.
- Providers and health plans will be able to query the registry for information on their patients.
- Patients will also be able to add and update information in the registry directly.[11]

To support PCPCHs as they prepare for this requirement, the Committee recommends adding two new measures (one 5-point and one 10-point) to this standard (4.C.1 and 4.C.2) that encourage practices to improve the proportion of their patients that have their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their EHR. A TAG should be convened to set a benchmark for the new 4.C.2. The Committee recommends that the benchmarks be flexible and take into consideration patients who are not comfortable providing REALD or SOGI information.

[11] Using REALD and SOGI to Identify and Address Health Inequities, OHA Equity and Inclusion Division

Standard 4.E: Specialized Care Setting Transitions

Current measure (must-pass):

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

Following up with patients that have recently been discharged from the hospital has been linked with reduced rates of readmission, emergency department use, and death. Given its potential to improve health equity, the Committee recommends parsing this activity out of 4.E.0 into its own 5-point measure (4.E.1) which would include additional expectations and guidance around post-discharge follow-up workflows. The Committee noted that formal written agreements with hospitals can be difficult for PCPCHs to obtain and could be administratively burdensome. The Committee therefore recommends that PCPCHs be permitted to demonstrate their process around effective hospital partnership and transitions of care through a policy or workflow as an alternative to a formal hospital agreement. Additional suggestions include renaming this standard to "*Hospital Setting Transitions*" and encouraging PCPCHs to engage in post-discharge follow-up in a way that is culturally and linguistically appropriate and considers patients' health literacy level.

Standard 5.A: Population Data Management

Current measures (check all that apply):

5.A.1 – PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its entire patient population, including the identification of sub-populations. (5 points)

5.A.2 – PCPCH demonstrates the ability to stratify its entire patient population according to health risk such as special health care needs or health behavior. (10 points)

Patients' level of health risk is impacted not only by health care needs and behaviors, but also by their HRSNs and demographic background. The Committee therefore recommends adding a new 15-point measure to this standard (5.A.3) that encourages PCPCHs to incorporate select demographic information or HRSN into their population data management activities. There was some debate as to whether the focus of this measure should be on incorporating these factors into PCPCHs' risk stratification processes, using this data to identify which factors most impact outcomes, or using it to identify sub-populations that would benefit from additional interventions. If going the aspirational route of risk stratification, the measure should be as flexible as possible due to the limitations of EHRs being able to integrate this data into risk-scoring, the lack of evidence-based best practices around leveraging HRSN and demographic data in this way, and the potential unintended consequences for patients. Additional suggestions include updating the measure language and specifications in 5.A.1 and 5.A.2 and changing this standard from a "check all that apply" to a progressive one.

Standard 5.E: Referral & Specialty Care Coordination

Current measures (check all that apply):

5.E.1 – PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians. (5 points)

5.E.2 – PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (e.g., hospital, SNF, long term care facility). (10 points)

5.E.3 – PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social services, foster care (either adult or child), public health, traditional health workers, school-based health centers, behavioral health providers and organizations, and pharmacy services. (15 points)

Over the past decade since measure 5.E.3 standard was created, many of the external "community services" referenced in the measure have been incorporated into the PCPCH model as distinct standards. The Committee therefore recommends updating this measure to focus on coordinating care for patients engaged with systems that are not captured elsewhere in the model such as public and private schools, adult and youth foster care, local public health agencies, and correction facilities—all of which serve as opportunities to improve patient health. Given the barriers practices sometimes face in this work related to information-sharing, lack of payment, and lack of collaboration, this measure should be flexible and allow practices to focus on the systems most relevant to their patient population. The Committee also recommends updating measure 5.E.2 to include in-patient behavioral health facilities and updating the title of this standard to "*Referral and Coordination with Specialists, Care Facilities and Government Systems.*"

Standard 6.A: Meeting Language and Cultural Needs

Current measures (progressive):

6.A.0 – PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their language of choice. (must-pass)

6.A.1 – PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic. (5 points)

Community partners, as well as the previous 2019 Committee, have highlighted the barriers that patients face when it comes to understanding written and verbal communications regarding their conditions, tests, treatments, and other information (e.g., registration forms, after-visit summaries, patient education materials, billing statements, etc.) – with some groups experiencing disproportionately lower rates of health literacy than others. The Committee therefore recommends

adding a new 10-point measure to this standard that encourages PCPCHs to take steps to assure that their commonly used patient materials and communications are at an appropriate health literacy level for their patient population. The Committee recommends convening a TAG to develop the specifications for this measure. To account for differences in patient need and systemic or legal constraints, the specifications should be process-oriented and flexible in how health literacy is defined and which materials and communications are in scope,. The Committee also recommends broadening the criteria for 6.A.1 to include PCPCHs that don't currently have a significant patient population whose primary language is not English but could translate materials to languages commonly spoken in their local community. Additional suggestions include changing the title of the standard to "*Meeting Language and Literacy Needs*," making this standard "check all that apply" instead of progressive, and promoting better-quality interpreter services and workflows in measure 6.C.0.

Standard 6.B: Education & Self-Management Support

Current measures (progressive):

6.B.1 – PCPCH provides patient-specific education resources to their patient population. (5 points)

6.B.2 – PCPCH provides patient-specific education resources and offers self-management support resources to their patient population. (10 points)

6.B.3 – PCPCH provides patient-specific education resources, offers self-management support resources to their patient population, and tracks utilization of multiple self-management groups. (15 points)

Community partners have highlighted the importance of primary care practices taking into consideration patients' language, background, and culture when providing patient education, self-management resources, and referrals. The Committee therefore recommends shifting the focus of this standard from tracking utilization of resources to encouraging PCPCHs to provide patient-specific education and self-management support that is culturally and linguistically appropriate, gender-affirming, and/or considering of intersectional identities. This would include removing the tracking requirement from 6.B.1 and merging 6.B.2 and 6.B.3 into one 10-point measure that incorporates both self-management support resources and self-management groups/specialists. There was some debate as to whether some other form of accountability should be included in this standard to replace the tracking requirement. The Committee also suggests encouraging PCPCHs to consider the health literacy level of their patient education and self-management resources.

Standard 6.C: Experience of Care

Current measures (progressive):

6.C.0 – PCPCH surveys a sample of its population on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. (must-pass)

6.C.1 – PCPCH surveys a sample of its population on their experience of care. The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. PCPCH also has a survey planning strategy in place and shares data with clinic staff. (5 points)

6.C.2 – PCPCH surveys a sample of its population on their experience of care using one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es). (10 points)

6.C.3 – PCPCH surveys a sample of its population on their experience of care using one of the CAHPS survey tools, meets the benchmarks, or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es). (15 points)

Although the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are some of the only validated survey tools with national benchmarking, the PCPCH Program has received significant feedback from practices over the years regarding the surveys' length, timeliness of results, the lack of provider-specific data offered by some vendors, the lack of gender-affirming language, the lack of up-to-date and reflective benchmarks[12] and barriers around integrating results with other survey dashboards. In line with the recommendations of the 2019 PCPCH Standards Advisory Committee, the 2022 Committee recommends shifting the focus of this standard from meeting or demonstrating improvement against the CAHPS benchmarks to using survey data to improve patient experience of care and advance health equity. This would involve eliminating the requirement that PCPCHs use CAHPS, removing measure 6.C.3 due to the lack of other generalizable survey benchmarks, combining 6.C.0 and 6.C.1 into one must-pass measure that allows PCPCHs to either meet a target for collected responses or demonstrate a strategy to increase this number, moving 6.C.2 down to 6.C.1, and creating a new 6.C.2 that builds on improvement activities and includes health equity among the areas of care on which PCPCHs survey their patients. Additional suggestions include providing PCPCHs with guidance around possible questions for each area of care – including health equity – and highlighting survey tools that are culturally and linguistically appropriate, gender affirming, or otherwise best practice.

[12] AHQR has not updated the CAHPS benchmarks since 2019 and has ceased collecting new data in early 2021. Pediatric benchmarks have not been updated since 2016. In addition, while the NCQA PCMH certification does give practices 1 credit for using CAHPS survey tools, meeting benchmarks or using benchmarks to demonstrate improvement is not part of their model. Finally, some of the CAHPS survey benchmarks are based predominately on the results of specialty care surveys, which has made it difficult for primary care practices to meet them.

New standards

The following is an overview of standards that do not yet exist within the PCPCH model but are being recommended for inclusion by the Committee. Each section includes background information, a summary of the Committee's discussion and proposed measure language for the new standard.

Standard 2.G: Value-Based Payments

VBP is one of OHA's primary strategies for achieving the Triple Aim of a healthy population, extraordinary patient care for everyone and reasonable costs shared equitably. Whereas the traditional fee-for-service payment model results in a fragmented system and unnecessary costs, transitioning to VBP increases flexibility and incentives for providers to deliver patient-centered, whole-person care. VBP can support PCPCH's team-based care and care management efforts that otherwise can't be reimbursed via a traditional fee-for-service payment system, such as outreach, traditional health workers (THWs), partnerships with community entities, and other non-billable types of care.

There are currently two PCPCH measures that incentivize and reward clinic efforts to leverage VBPs to improve their performance on quality and utilization measures. Below are the measures that were added to the model in 2020:

> **Current measure in 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)

> **Current measure in 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)

To further advance VBP adoption, OHA developed a VBP Roadmap for Coordinated Care Organizations which expects that at least 70% of their payments to providers are in the form of a VBP by 2024. The Health Care Payment and Learning Action Network (HCP-LAN) categories are the framework according to which CCOs are held accountable for reporting their VBP payments to providers. In addition, some other commercial payers and Medicare are also using the HCP-LAN framework in their payment arrangements. Other work in Oregon to advance the adoption of VBPs includes a primary care payment model being developed by the Primary Care Payment Reform Collaborative. This payment model will be recommended to the Oregon Value-Based Payment

Compact workgroup for voluntary adoption by payers and providers statewide as part of a strategy to achieve the goals of Oregon's Sustainable Health Care Cost Growth Target Program.

To encourage health system alignment and transformation towards VBPs, the Committee recommends replacing measures 2.A.1 and 2.E.1 with a distinct PCPCH standard focused on VBPs as defined by the HCP-LAN categories. Measure 2.G.3 would encourage PCPCHs to move from VBPs with HCP-LAN category 2C (pay-for-performance) to VBPs with HCP-LAN category 3A (shared savings) and higher. While the recommended measure language and point values are as follows, OHA should consider modifying this language in the future to align with any statewide changes to VBP initiatives.

Proposed Standard 2.G – Value-Based Payments (progressive):

2.G.1 – PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with one payer. (5 points)

2.G.2 – PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with at least two payers or with one payer that covers a significant portion of the practice's patient population. (10 points)

2.G.3 – PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 3A or higher with at least two payers or with one payer that covers a significant portion of the practice's patient population. (15 points)

A TAG should be convened to determine how "significant portion of the practice's patient population" will be defined for these measures and should consider a lower threshold for higher VBP categories or for specific practice types.

Standard 5.G: Health Care Cost Navigation

During the 2021 PCPCH community listening sessions, community partners highlighted the primary care inequities driven by difficulties navigating the health care system such as applying for insurance, understanding what services are covered by insurance, and knowing where to call with questions. They also brought up barriers related to the cost of care including appointments, medications, specialists, and treatments. Navigating the health care payment system can be especially difficult for patients who are unfamiliar with it (youth, immigrants, refugees, migrant workers, etc.), those with low health literacy, or those whose primary language is not English. This feedback aligns with Oregon and national assessments which have found that between 10%-40% of adults report delaying or going without medical care due to cost concerns — with the proportion being higher among specific ethnic groups, geriatric populations, and those who are low-income.[13] Surveys also suggest that between 35%-44% of Americans avoid care when faced with uncertainty about the cost.[14]

[13] Kaiser Permanente (2022), Kaiser Family Foundation (2022), Oregon Health Authority (2022)
[14] AKASA (2022), Healthcare Finance (2022)

To improve cost transparency, CMS enacted the Transparency in Coverage Act in 2022 which requires health plans to post pricing information for covered items and services, as well as provide access for consumers to pricing information to help inform their choice of the best care to meet their needs. In primary care, the NCQA PCMH model includes an optional standard which encourages medical homes to address some of these barriers by engaging with patients regarding the cost implications of treatment options, providing information about current coverage, and making connections to financial resources as needed.

To align with these national efforts, the Committee recommends adding a new "check all that apply" standard to the PCPCH model that encourages practices to increase cost transparency for visits, services, treatments, and medications, as well as assist their patients in navigating their payment options. PCPCHs could be awarded 5 points for sharing information with patients about preventive services that typically do not require cost-sharing[15] and 15 points for assisting patients in navigating the cost and payments options for their care. A TAG should be convened to develop the specifications for these measures, which should be flexible to account for the often-changing expectations among health plans when it comes to cost-sharing and the barriers that primary care practices face in being able to provide patients with accurate cost estimates for external services. The recommend measure language and point values are as follows:

> **Proposed Standard 5.G – Health Care Cost Navigation (check all that apply):**
>
> **5.G.1** – PCPCH informs their patients of preventive services that do not require cost-sharing. (5 points)
>
> **5.G.3** – PCPCH assists its patients in navigating the cost and payment options for their care. (15 points)

Standard 6.E: Cultural Responsiveness of Workforce

One of the most frequent types of feedback the PCPCH Program received during its 2021 community listening sessions concerned the lack of adequate culturally responsive care in the health system. This included the lack of culturally specific referrals; dismissal of traditional healing practices; a lack of representation among providers and staff; systemic racism; underutilization of THWs; lack of trauma-informed care; and general misunderstandings about how a person's culture, priorities, identity, and social circumstances guides their decision-making — all of which, it was emphasized, reduces patient trust in health care.

National efforts to improve quality of care in this area have gained some traction in recent years. For example, the NCQA PCMH Model features standards related to delivering culturally and linguistically

[15] Many preventive services are covered under the Affordable Care Act, covered by the Oregon Health Plan, covered by Medicare, or covered under most private insurance plans.

appropriate care. NCQA offers a health equity accreditation that promotes diversity, equity, and inclusion among staff. In Oregon, the 2019 PCPCH Standards Advisory Committee requested that future Committees discuss the inclusion of THWs in the PCPCH model. The prior Committee noted the potential of THWs to assist clinics when it comes to delivering trauma-informed care and improving patient health and trust.

This Committee therefore recommends adding a distinct standard to the model that encourages PCPCHs to take steps to understand their patient population and ensure that their workforce is culturally responsive, trauma-informed, and fosters trust with their patients. PCPCHs could meet the first measure in this standard by training their staff on delivering care that is either culturally and linguistically appropriate, trauma-informed, or trust-building — depending on what is most relevant to their patient population — and could meet the second, higher-point measure by partnering with one or more THWs or THW services.[16] A TAG should be convened to develop the specifications for these measures, which should consider all characteristics that may impact patients' health and experience of care, as well as guidance around offering trainings and THW services in a meaningful way. The recommend measure language and point values are as follows (see section of this report titled Required (must-pass) measures for additional background around 6.E.0 on page 30):

Proposed Standard 6.E – Cultural Responsiveness of Workforce:

6.E.0 – PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care. (must-pass)

6.E.3 – PCPCH partners with one or more traditional health workers or traditional health worker services. (15 points)

[16] For the purposes of this measure, THWs could refer to any of the official THW types outlined by OHA's Equity and Inclusion Division. Staff serving as THWs could have other roles at the practice as well but would need to be certified as a THW by the Oregon Health Authority or the Oregon Home Care Commission.

Revisions to PCPCH model

The following is an overview of the broad, structural changes to the PCPCH model that the Committee is recommending. These include proposals around the required (must-pass) measures, special designations, and the point thresholds for various tier levels.

Required (must-pass) measures

Each of the six PCPCH Core Attributes contains at least one measure that is required for all PCPCHs — referred to as "must-pass" measures. Practices must currently meet 11 must-pass measures to become recognized as a PCPCH. This number has remained unchanged since 2017 (prior to 2017, practices had to meet 10 required measures).

Adding more required measures encourages practices to continue to transform and evolve in the Program. However, the Committee noted that practices have been experiencing unprecedented staff shortages which have made it difficult to meet certain measures that may have been achievable in the past. Due to these circumstances, the Committee recommends that only the following three measures be added to the required list — bringing the total number of must-pass measures up to 14 (or 13 if the Committee's recommendations around Standard 4.B are adopted). These three measures were selected due to their feasibility even for practices facing workforce challenges. It is important that current PCPCHs be given ample time to learn about and adopt these newly required measures to ensure that they are able to maintain recognition.

Standard 4.F.1 (proposed 4.F.0) – Planning for Continuity

This measure expects PCPCHs to demonstrate a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available. About 97% of PCPCHs are currently meeting this measure, as this is standard practices for most clinics.

Standard 6.D.1 (proposed 6.D.0) – Communication of Rights, Roles & Responsibilities

This measure expects PCPCHs to make patients, family members, or caregivers aware of their rights, roles, and responsibilities, as well as those of the clinic, at the onset of the care relationship. About 80% of PCPCHs are currently meeting this measure. Given the importance of building this foundation with patients and the relatively low administrative burden this measure poses, it is the feeling of this Committee that all PCPCHs should be providing this service.

Standard 6.E.0 (newly proposed)

This is a new measure recommended by the Committee that encourages PCPCHs to train their staff in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care — whatever is most relevant to their specific patient population (see New standards section of report for additional details on page 25). Though this is a new measure, it is important that the list of must-pass measures include at least one that is centered around improving health equity as this is a foundational value of the PCPCH Program. If the specifications for this measure are flexible (allowing practices to either offer

this training directly or partner with external entities) and include guidance around free or low-cost training resources, then it is likely that all PCPCHs will be able to integrate this measure into their operations and culture.

Retiring the 5 STAR designation

The 3 STAR designation—now called 5 STAR—was created in 2014 as a way for PCPCHs to distinguish themselves from other PCPCHs by meeting multiple advanced measures in the model. At that time, 93% of PCPCHs were recognized as a Tier 3, the highest tier level. To receive the designation a practice needed to be recognized as a Tier 3 PCPCH, attest to meeting several advanced 3 STAR measures and have a site visit by the PCPCH Program staff to verify the practice was meeting all the measures. In 2017, the PCPCH model was expanded to four tiers and 3 STAR was renamed 5 STAR with the designation criteria staying the same.

Over the last seven years, over 100 practices have achieved the 5 STAR designation, and it is not necessarily the indicator of a top performing PCPCH as it was once intended to be. Among the 5 STAR PCPCHs, there is significant variation in the number of measures attested to (points ranging from 255 to 430), with some practices attesting to the minimum number of measures required for the designation and others attesting to almost every measure in the model. In addition, not all PCPCHs attesting to advanced measures are able to achieve the 5 STAR designation. Many small, rural, and pediatric Tier 4 PCPCHs have told the Program that 5 STAR is not achievable for them because their practice lacks the resources, capacity, and infrastructure to meet the multiple advanced 5 STAR measures needed for the designation.

Further, the 5 STAR designation requires significant PCPCH Program staff resources. For the past several years, PCPCH Program staff have been mostly conducting site visits to 5 STAR PCPCHs (as noted above, a requirement before the 5 STAR designation is awarded) which means that lower tier level practices are not receiving the same resources and technical support from the PCPCH Program. With the Program's limited staff and resources, there are PCPCHs that have never received a site visit.

Because of these factors, the Committee recommends retiring the 5 STAR designation and adding a Tier 5 that is based solely on level of engagement with the overall model (total number of points). This would allow PCPCH Program staff to dedicate more technical assistance to the PCPCHs with fewer resources while also giving practices that currently don't have the resources to meet the advanced 5 STAR measures the opportunity to achieve the highest tier level.

Special designations

OHA has set a 10-year strategic goal of eliminating health inequities by the year 2030. The PCPCH Program is uniquely positioned to implement strategies that support this goal. The Committee therefore recommends creating a special "Equity STAR" designation to encourage PCPCHs to prioritize

standards that have been identified as improving health equity. An Equity STAR Designation Advisory Committee should be convened to identify which measures or other requirements should be included in the Equity Star designation criteria. If the recommendations of this Committee are adopted throughout the model, there will be a variety of standards to consider as options for inclusion in the designation. The criteria should be flexible enough to account for differences in need across patient populations. Finally, to facilitate adoption of these standards among practices of all sizes and resource levels, the Committee recommends that this Equity Star designation be attainable for PCPCHs at any tier level.

There was discussion on whether to also recommend a special "Behavioral Health Integration" designation, but there were concerns that this would silo behavioral health services, particularly in the absence of comparable special designations for integrating other areas of care such as oral health.

Tier point distribution

Except for the 11 required must-pass measures (which are assigned no points) each measure in the PCPCH model is assigned a value of 5, 10 or 15 points. Primary care practices attest to meeting measures in the standards and their PCPCH tier level is determined by the total number of points for the measures attested to.

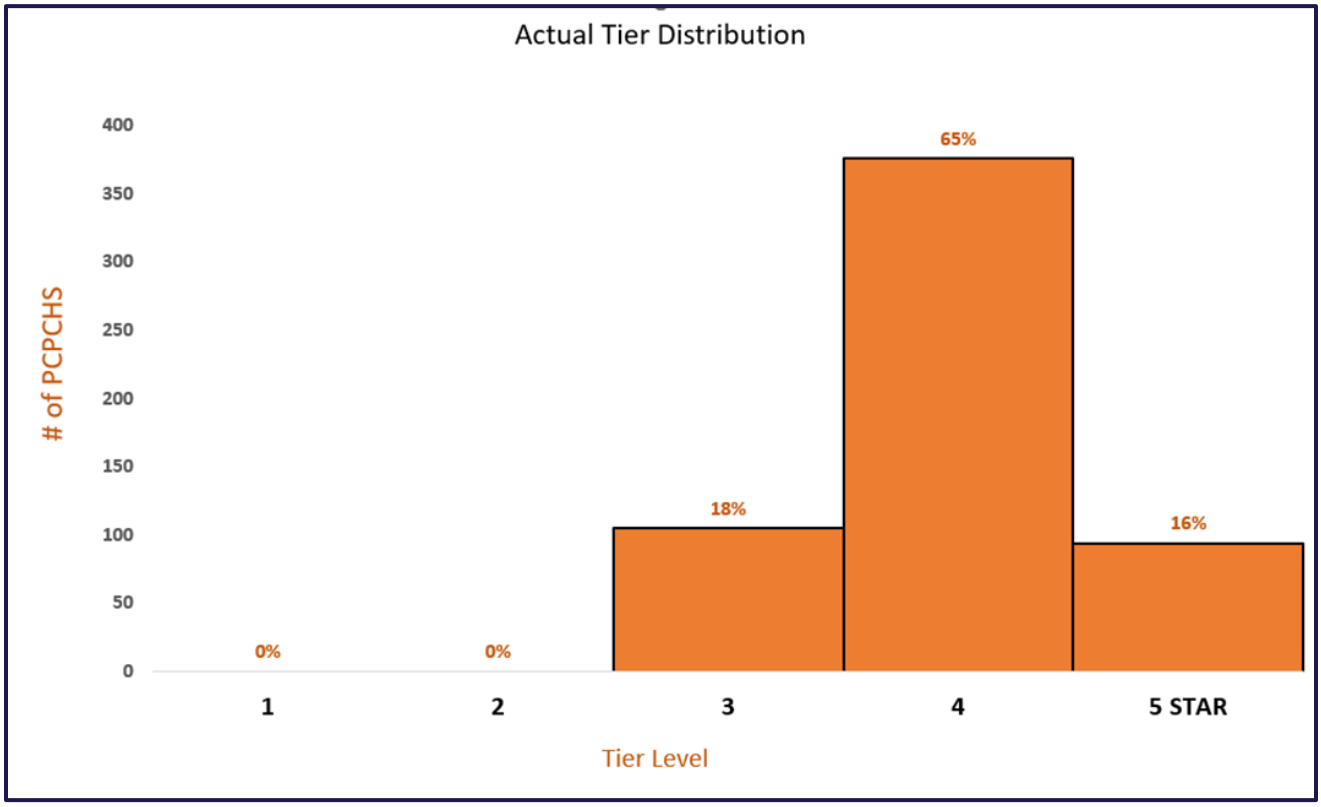
The current point distribution for PCPCH tier levels is skewed so that the top tier levels have the largest point distribution (Figure 2). For example, a PCPCH that attests to measures totaling 255 points is meeting significantly fewer measures than a PCPCH that attests to 430 points, yet both are a Tier 4.

Figure 2: 2020 PCPCH Tier Levels

Tier Level	Point Range	Point Distribution
Tier 1	30 – 60	30 points
Tier 2	65 – 125	55 points
Tier 3	130 – 250	120 points
Tier 4	255 – 430	175 points
5 STAR	255 – 430 and additional 5 STAR criteria	175 points

This uneven point distribution structure has resulted in 81% of PCPCHs achieving a Tier 4 or 5 STAR. There are currently no Tier 1 or Tier 2 PCPCHs (Figure 3). The PCPCH tier structure was designed as a framework to encourage transformation and quality improvement. Under the current tier point distribution, once PCPCHs reach the Tier 4 level, there is little incentive for them to attest to additional measures or seek opportunities to advance.

Figure 3: PCPCHs Recognized at each Tier Level (2020 PCPCH Recognition Criteria)



Given the skewed point distribution and its impact on tier level advancement, the Committee recommends that the points for each tier level be evenly distributed so that PCPCHs that have attested to a similar number of measures (points) have the same tier level. This change would also provide more PCPCHs an opportunity for continued transformation and improvement. Further, the Committee recommends raising the minimum points for Tier 1 from 30 to 60 and adding a Tier 5 that can be achieved by points alone. (See section of this reported titled Revisions to PCPCH model on page 30 for additional details on recommendations around must-pass measures, 5 STAR designation, and Equity STAR designation). Figure 4 shows the recommended tier levels.

Figure 4: PCPCH Tier levels Recommended by Committee

Tier Level	Point Range	Point Distribution
Tier 1	60 – 150	90 points
Tier 2	155 – 245	90 points
Tier 3	250 – 340	90 points
Tier 4	345 – 435	90 points
Tier 5	440 – 530	90 points

Note that the 2019 PCPCH Standards Advisory Committee recommended changing the tier point distribution as well, but this was not implemented by OHA due to the COVID-19 pandemic.

It is difficult to estimate how these changes would impact any PCPCH's tier since all practices attest to different measures and — if the Committee's recommendations throughout the model are adopted — there would be more total measures and points available and more flexible expectations in some of the current standards. That said, it is likely that some practices would see a reduction in their tier level under these revised standards if they did not attest to any additional measures. PCPCH Program staff acknowledge the financial impact a reduced tier level could have on a PCPCH that is receiving a payment from a CCO or other payer based on their PCPCH tier level. The Program will communicate proactively to payers that a tier reduction in the revised standards does not necessarily mean a practice is meeting fewer measures. The Program will also strongly advocate that CCOs and payers continue to sustain current payments to all PCPCHs to ensure that low-resource practices do not lose the funding they need to provide high quality primary care.

Finally, PCPCH Program staff have observed that people often misunderstand the meaning of tier levels due to the popularity of other common evaluation systems that associate 1 with low quality and 5 with good quality. The Committee therefore suggests transitioning from tier-based language to award-based imagery (e.g., bronze, silver, gold, platinum, and diamond) to reduce misunderstandings about the meaning of tier levels and better represent the high-quality care that all PCPCHs provide, regardless of tier level.

Implementation of Committee recommendations

Beginning in April 2023, OHA will review the Committee recommendations presented in this report along with other community 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 2023 by PCPCH staff and be consistent with the recommendations of the Committee. Selected Committee members, community partners and content experts will comprise a TAG to help Program staff to update and revise selected measures.

The PCPCH Program will convene an advisory group to assist in the development of the Equity STAR designation criteria in mid-2023.

OHA will implement the final revised standards and technical specifications in mid-2024, at which point primary care clinics will begin applying for PCPCH recognition under the revised model.

Future areas of focus

In addition to recommendations for the current PCPCH model, this Committee has identified the following areas of focus to be considered in future discussions about model refinements.

Standard 2.E – Ambulatory Care Sensitive Conditions Utilization: The Committee has recommended adding a new 15-point measure to Standard 2.E that encourages PCPCHs to identify patients experiencing disparities in unplanned or adverse utilization patterns and contact them for follow up. In the future, OHA may want to consider adding an additional measure recognizing PCPCHs that are able to demonstrate improvement in utilization metric outcomes.

Standard 2.G – Value-Based Payment: The Committee has recommended adding a new standard to the model that encourages PCPCHs to adopt VBP arrangements in the HCP-LAN category 2C or higher. OHA should monitor health system progress, changes, and developments arising from initiatives such as Oregon's Primary Care Payment Reform Collaborative and modify this standard accordingly.

Standard 3.D - Health-Related Social Needs (HRSN): Committee members provided mixed feedback regarding the proposed HRSN screening minimum, with some emphasizing the benefits of flexibility and alignment with CCO expectations, and others suggesting requiring PCPCHs to screen for more than three HRSN or awarding more points to practices that screen for a greater number. Some recommended adding an additional measure to this standard which would encourage PCPCHs to identify and address the HRSN in their wider community through community-based partnerships.

Standard 4.C – Organization of Clinical Information: The Committee has recommended adding a new 5-point measure to Standard 4.C that encourages practices to document their patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record (proposed 4.C.1). Given the relevance of this data to clinic-level efforts to improve health equity, OHA should consider making this a must-pass in future iterations of the model.

Standard 6.E - Cultural Responsiveness of Workforce: The Committee has recommended adding a new Standard to the model that encourages PCPCHs to take steps to understand their patient population and ensure that their workforce is culturally responsive through trainings and use of THWs. There was a suggestion to also add a measure to this standard that encourages practices to integrate staff that reflect the diversity of their patient population. It was noted, though, that practices face significant systemic challenges in doing this, including the lack of available workforce. Future Committees are encouraged to revisit this idea if these systemic barriers are reduced.

HEALTH POLICY AND ANALYTICS
Delivery System Innovation Office

Patient-Centered Primary Care Home Program
Email: PCPCH@oha.oregon.gov

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.

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.

Appendix B: PCPCH Standards Advisory Committee 2022 charter

I. Authority

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 though 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

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;
2. New standards or measures related to health equity for inclusion in the PCPCH model; and
3. Model revisions, such as must pass measures, special designations, and tier point thresholds.

The Committee will convene monthly from August 2022 to January 2023 to discuss what is listed above and will deliver a written report with recommendations to OHA on the revisions to the PCPCH model by February 2023. 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 committee should focus on reducing health inequities, where possible, into the model and align with OHA's strategic goal of eliminating health inequities by 2030;
- The committee should assess clinical and social conditions, as well as the historical and contemporary injustices, which undermine health, when considering revisions to the measures and standards in 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 Tier 5 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 away 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 equity, 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 2022 Committee members represent diverse stakeholder perspectives across primary care, including providers, payers, patients, behavioral health providers, oral health, substance use, traditional health workers, health equity advocates, community-based organizations, and social determinants of health experts. Members represent all areas of the state, including rural and frontier communities.

Appendix C: PCPCH Standards Advisory Committee 2022 Committee Roster

Ben Hoffman, M.D., CPST-I, FAAP
Professor of Pediatrics, Director of Oregon Center for Children and Youth with Special Health Needs
Oregon Health & Science University
Portland, OR

Brieshon D'Agostini
Quality and Compliance Officer
Multnomah County Health Center
Portland, OR

Chanel Smith
Director of Quality Management
Cascade Health Alliance, CCO
Klamath Falls, OR

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

Elizabeth Powers, MD, MPH
Primary Care Provider, Chief Integration Officer
Winding Waters Health Center
Enterprise, OR

Emily Morgan, MD
Assistant Professor of Internal Medicine & Geriatrics
Oregon Health & Science University
Portland, OR

Erica Gilliland, QMHP
Qualified Mental Health Provider
Wallow Memorial Hospital and Medical Clinic
Enterprise, OR

Heather Whetstone, MD
Primary Care Provider
Providence Medical Group North Portland Family Medicine
Portland, OR

Jennifer Miller, RHIT
Administrative Support & Medical Supervisor
Bridgeway Recovery Services
Salem, OR

Katie Cox
Executive Director
The Equi Institue
Portland, OR

Larissa Mejia-Medina, BSN, RN
Quality Improvement Nurse Director
Rogue Community Health Center
Medford, OR

Laura McKeane, EFDA
Director of Oral Health Services
AllCare Health
Grants pass, OR

Leah Lorincz, RN
Clinical Program Consultant
Cambia Health Solutions
Coos Bay, OR

Lynnea Lindsey, PhD, MSCP
Oregon Network Director,
Behavioral Health Service Line
Peace Health
Eugene, OR

Maria Fife, FNP, DNP
Family Nurse Practitioner, Clinic Owner
Canyon Family Health
Stayton, OR

Nicole Norris
Chief Quality Officer, Social Health Program Manager
Waterfall Community Health Center
North Bend, OR

Sarah Deines, PharmD, BCACP, CPHQ
Director of Quality Improvement
Virginia Garcia Memorial Health Center
Hillsboro, OR

Scott Fields, M.D., MHA
Chief Medical Officer
OCHIN
Portland, OR

Shayla Nice
Patient Representative
Disability Rights Oregon
Portland, OR

Stacie Wolfe, N.D.
Primary Care Provider, Clinical Director
Center for Natural Medicine
Portland, OR

Stephanie Williams
Traditional Health Worker
Oregon Family Support Network
Pendleton, OR

Teresa Allen
Clinic Administrator
Thurston Medical Clinic
Eugene, OR

Appendix D: Summary of recommended changes to the 2020 PCPCH model

The following document summarizes the proposed revisions to the 2020 PCPCH model recommended by the PCPCH Standards Advisory Committee. Please refer to the following definitions when using this document:

Unchanged:	This measure is part of the 2020 criteria and there are no proposed changes to language and/or point valu.es
Revised:	This measure is part of the 2020 criteria but there are proposed changes to language and/or point values.
New:	This measure is not part of the 2020 criteria and is proposed as a new measure to the model.
Removed:	This measure is part of the 2020 criteria but is being proposed as being deleted from the model.

The advisory committee recommends that OHA increase the number of must-pass standards to 13 by deleting one (4.B.0), adding three (4.F.0, 6.D.1, and 6.E.0) and revising others (2.A.0, 4.A.0, 4.E.0, 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 530 points (up from a total of 430 points in the 2020 model).

PCPCH Model Proposed Changes Overview

	Current PCPCH model	**Proposed change to PCPCH model**
Required measures	11 “must pass” measures	13 “must pass” measures including one new equity measure
Tier point distributions	Tier 1 30 – 60 points Tier 2 65 – 125 points Tier 3 130 – 250 points Tier 4 255 – 430 points 5 STAR 255-430 points, meet specific 5 STAR measures and receive a verification site visit from the PCPCH program.	Tier 1 60 – 150 points Tier 2 155 – 245 points Tier 3 250 – 340 points Tier 4 345 – 435 points Tier 5 440 – 530 points *Based on the revisions the committee has discussed, it is estimated the revised standards will have 530 total points available.*
Special designations	**5 STAR** for high performing PCPCHs only. Requires meeting specific measures and a site visit by PCPCH program staff.	**Equity STAR** for a PCPCH at any tier level that meets specific equity measures

PCPCH Standards and Measures Proposed Changes

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

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

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
~~Standard 2.B) Public Reporting~~			
~~**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.~~	Removed	~~No~~	~~5~~
Standard 2.C) Patient and Family Involvement in Quality Improvement			
2.C.1 PCPCH involves patients, families, and caregivers as advisors on at least one quality or safety initiative per year.	Unchanged	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development and/or educational improvement activities.	Unchanged	No	10
2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	Unchanged	No	15
Standard 2.D) Quality Improvement			
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.	Unchanged	No	5
2.D.2 PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	Unchanged	No	10
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

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 2.E) Ambulatory Care Sensitive Conditions Utilization *(Check all that apply)*			
~~**2.E.1** PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure.~~	**Removed**	~~**No**~~	~~**5**~~
2.E.2 PCPCH identifies patients experiencing unplanned or adverse patterns **in at least one utilization measure** and contacts patients, families or caregivers for follow-up care.	**Revised**	No	10
2.E.3 PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families or caregivers for follow-up care.	**Revised**	No	15
Standard 2.F) PCPCH Staff Vitality			
2.F.1 PCPCH uses a structured process to identify opportunities to improve the vitality of its staff.	Unchanged	No	5
2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	Unchanged	No	10
Standard 2.G) Value-based Payment			
2.G.1 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with one payer.	**New**	No	5
2.G.2 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with at least two payers or with one payer that covers a significant portion of the practice's patient population.	**New**	No	10
2.G.3 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 3A or higher with at least two payers or with one payer that covers a significant portion of the practice's patient population.	**New**	No	15

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - *"Provide or help us get the health care, information, and services we need."*			
Standard 3.A) Preventive Services			
3.A.1 PCPCH routinely offers or coordinates recommended preventive services appropriate for its 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 service 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
Standard 3.B) Medical Services			
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.	Unchanged	**Yes**	0
Standard 3.C) Behavioral Health Services *(Check all that apply – **maximum 35 points**)*			
3.C.0 PCPCH has a **routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.**	**Revised**	**Yes**	0
3.C.2.a PCPCH collaborates or is co-located with specialty mental health, substance use disorder, and developmental providers.	**Revised**	No	**10**
3.C.2.b PCPCH provides pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	**Revised**	No	10
3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	Unchanged	No	15

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 3.D) Health-Related Social Needs *(Check all that apply)*			
~~**3.D.1** PCPCH has a routine assessment to identify health-related social needs in its patient population.~~	Removed	~~No~~	~~5~~
3.D.2 PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.	Revised	No	10
3.D.3 PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.	Revised	No	15
Standard 3.E) Preventive Services Reminders			
3.E.1 PCPCH generates lists of patients who need reminders for preventive services and ensures they are sent appropriate reminders.	Revised	No	5
3.E.2 PCPCH generates lists of patients who need reminders for preventive services, ensures they are sent appropriate reminders, and tracks the completion of those recommended preventive services.	Revised	No	10
3.E.3 PCPCH generates lists of patients who need reminders for preventive services, ensures they are sent appropriate reminders and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach strategy.	New	No	15
Standard 3.F) Oral Health Services			
3.F.1 PCPCH utilizes a screening and/or assessment strategy for oral health needs.	Unchanged	No	5
3.F.2 PCPCH utilizes a screening and or/assessment strategy for oral health needs and provides age-appropriate interventions.	Unchanged	No	10
3.F.3 PCPCH provides oral health services by dental providers.	Unchanged	No	15

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*			
Standard 4.A) Personal Clinician Assignment & Continuity			
4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team **and has a process for considering patient choice in assignment. PCPCH also reports the percent of visits in which a patient saw their assigned clinician or team.**	**Revised**	**Yes**	0
4.A.2 PCPCH tracks and improves the percent of visits in which a patient saw their assigned clinician or team.	**Revised**	No	10
4.A.3 PCPCH meets a benchmark for the percent of visits in which a patient saw their assigned clinician or team.	**Revised**	No	15
~~**Standard 4.B) Personal Clinician Continuity**~~			
~~**4.B.0** PCPCH reports the percent of patient visits with assigned clinician or team.~~	**Removed**	~~**Yes**~~	~~0~~
~~**4.B.2** PCPCH tracks and improves the percent of patient visits with assigned clinician or team.~~	**Removed**	~~No~~	~~10~~
~~**4.B.3** PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.~~	**Removed**	~~No~~	~~15~~
Standard 4.C) Organization of Clinical Information			
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified through the **Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program** and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.	**Revised**	**Yes**	0
4.C.1 PCPCH documents their patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record.	**New**	**No**	**5**
4.C.2 PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.	**New**	**No**	**10**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 4.D) Clinical Information Exchange			
4.D.2 PCPCH exchanges clinical information electronically to another provider or setting of care.	Unchanged	No	10
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities **through an** electronic health information exchange.	**Revised**	No	15
Standard 4.E) Hospital ~~Specialized Care~~ Setting Transitions			
4.E.0 PCPCH has a **documented process for transitions of care** with its usual hospital providers or directly provides routine hospital care.	**Revised**	**Yes**	0
4.E.2 PCPCH implements a process for following up with their patients post-discharge from the hospital and emergency department.	**New**	**No**	**10**
Standard 4.F) Planning for Continuity			
4.F.0 PCPCH demonstrates a process for reassigning administrative requests, prescription refills, and clinical questions when a provider is not available.	**Revised**	**Yes**	**0**
Standard 4.G) Medication Reconciliation and Management *(check all that apply)*			
4.G.2 PCPCH has a process for medication reconciliation for patients with complex or high-risk medication concerns.	Unchanged	No	10
4.G.3 PCPCH provides Medication Management for patients with complex or high-risk medication concerns.	Unchanged	No	15

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - *"Help us navigate the health care system to get the care we need in a safe and timely way."*			
Standard 5.A) Population Data Management ~~*(Check all that apply)*~~			
5.A.1 PCPCH uses data on its entire patient population to track overall health needs or engage in proactive patient population management.	**Revised**	No	5
5.A.2 PCPCH stratifies its entire patient population according to health risk.	**Revised**	No	10
5.A.3 PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category such as race, ethnicity, language, disability, sexual orientation, or gender identity.	**New**	**No**	**15**
Standard 5.C) Complex Care Coordination *(Check all that apply)*			
5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care.	Unchanged	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs.	Unchanged	No	10
5.C.3 PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns.	Unchanged	No	15
Standard 5.D) Test & Result Tracking			
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely, confidential notification and explanation of results to patients, family, or caregivers as well as to ordering clinicians.	Unchanged	No	5

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
Standard 5.E) Referral and Care Coordination with Specialists, Care Facilities and Governmental Systems *(Check all that apply)*			
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients, families, or caregivers and clinicians.	Unchanged	No	5
5.E.2 PCPCH coordinates care when its patients receive care in specialized settings such as hospitals, skilled nursing or other long-term care facilities, **and in-patient behavioral health facilities**.	**Revised**	No	10
5.E.3 PCPCH coordinates care for its patients who are engaged with or receiving services from the Oregon Department of Human Services, criminal justice, education or public health systems.	**Revised**	No	15
Standard 5.F) End of Life Planning			
5.F.0 PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	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
Standard 5.G) Health Care Cost Navigation ***(check all that apply)***			
5.G.1 PCPCH informs their patients of preventive services that do not require cost-sharing.	**New**	**No**	**5**
5.G.3 PCPCH assists its patients in navigating the cost and payment options for their care.	**New**	**No**	**15**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - *"Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."*			
Standard 6.A) Meeting Language & Health Literacy ~~Cultural~~ Needs *(check all that apply)*			
6.A.0 PCPCH offers time-of-service interpretation to communicate with patients, families, or caregivers in their **primary language**.	**Revised**	**Yes**	0
6.A.1 PCPCH provides written patient materials in languages **other than English**.	**Revised**	No	5
6.A.2 PCPCH assures that patient communications and materials are at an appropriate health literacy level.	**New**	**No**	**10**
Standard 6.B) Education & Self-Management Support			
6.B.1 PCPCH provides **culturally and linguistically appropriate** patient-specific education resources to their patient population.	**Revised**	No	5
6.B.2 PCPCH provides **culturally and linguistically appropriate** patient-specific education resources and **offers or connects patients, families, and caregivers with self-management support resources**.	**Revised**	No	10
~~**6.B.3** PCPCH provides patient-specific education resources, offers self-management support resources to their patient population, and tracks utilization of multiple self-management groups.~~	**Removed**	~~No~~	~~15~~
Standard 6.C) Experience of Care			
6.C.0 PCPCH surveys a sample of its population on their experiences with specific areas of care and shares results with clinic staff. **PCPCH also meets a survey completion benchmark or has a strategy to increase the number of surveys completed.**	**Revised**	**Yes**	0

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available
6.C.1 PCPCH surveys a sample of its population on their experiences with specific areas of care **and demonstrates the utilization of survey data in quality improvement activities.**	**Revised**	No	5
6.C.2 PCPCH surveys a sample of its population on their experiences with specific areas of care**, including health equity,** and demonstrates the utilization of survey data in quality improvement activities.	**Revised**	No	10
~~**6.C.3** PCPCH surveys a sample of its population on their experience of care using of one of the CAHPS survey tools, meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).~~	**Removed**	~~No~~	~~15~~
Standard 6.D) Communication of Rights, Roles, and Responsibilities			
6.D.0 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.	**Revised**	**Yes**	**0**
Standard 6.E) Cultural Responsiveness of Workforce			
6.E.0 PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.	**New**	**Yes**	**0**
6.E.3 PCPCH partners with one or more traditional health workers or traditional health worker services.	**New**	**No**	**15**