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PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

2025 PCPCH Recognition Criteria

October 3, 2024
Oregon Rural Health Conference

Agenda

- 2025 Patient-Centered Primary Care Home (PCPCH) Standards overview
- Implementation strategies for rural practices
  - PCPCH Measure 4.C.2
  - PCPCH Measure 5.B.3
  - PCPCH Measure 6.E.3
- Questions and answers

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2025 PCPCH Standards overview

How the 2025 PCPCH Standards were developed

- Revised every few years since 2009
- Informed by community listening sessions
- Developed with Standards Advisory Committee
- Align with OHA goal of eliminating health inequities by 2030
- Support PCPCHs to build capacity to address inequities in patient population

Revised standards to improve equity

Many measures have been revised to **improve equity**, such as supporting PCPCHs to:

- Provide access to interpreter services for both in-person and telehealth appointments.
- Document a patient's race, ethnicity, language, disability, sexual orientation, or gender identity (REALD/SOGI) in the electronic health record.
- Assure patients are screened for health-related social needs and can access the appropriate intervention if needed.
- Assure referrals and education materials are culturally and linguistically appropriate.

Revised standards to improve implementation

Some measures have been revised to **reduce administrative burden for practices and improvement overall implementation** such as:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is no longer required.
- Select quality and utilization measures from existing metrics lists (such as CCO incentive measures, CMS Adult and Child Core metric list).
- Removed or revised outdated processes and tracking requirements.
- Reduced documentation required to demonstrate meeting a measure during a verification site visit from OHA.

New must-pass measures

Three new must-pass measures; bringing the total to 13 measures

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

New health equity designation

- This designation encourages PCPCHs to prioritize health equity in their practices
- PCPCH must meet 15 of 20 equity-focused measures to qualify
- PCPCH at any tier level can achieve the designation
- Practices will apply for the designation at the same time they apply or re-apply for PCPCH recognition
- PCPCH program staff will verify practices are meeting the equity-focused measures before the designation is awarded

New tier level recognition structure

- Returning to three tier levels with more evenly distributed points
- Greater emphasis on quality improvement
- Ensure PCPCHs meeting a similar number of measures are same tier level

2020 PCPCH Tiers			2025 PCPCH Tiers		
Tier level	Point range	Point distribution	Tier level	Point range	Point distribution
Tier 1	30-60	30 points	Tier 1	n/a	n/a
Tier 2	65-125	55 points	Tier 2	n/a	n/a
Tier 3	130-250	120 points	Tier 3	100-245	145 points
Tier 4	255-430	175 points	Tier 4	250-390	140 points
5 STAR	255-430	175 points	Tier 5	395-530	135 points

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Implementation strategies for rural practices

PCPCH measure 4.C.2

Documenting race, ethnicity, language, disability, sexual orientation, and gender identity

PCPCH standard 4.C Organization of Clinical Information

Measures

4.C.0 - PCPCH uses an electronic health record (EHR) technology that is certified by the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program … (must pass)

4.C.1 - PCPCH documents their patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record. (5 points)

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. (10 points)

PCPCH measure 4.C.2 intent

- Collecting REALD and SOGI information will help your practice understand who is most impacted by health inequities.

- Your practice will be more informed about your patients that may need additional resources and support to be healthy and thrive.

- Aligns with OHA's strategic goal of eliminating health inequities

PCPCH Measure 4.C.2 Specifications

To meet this measure a PCPCH must:

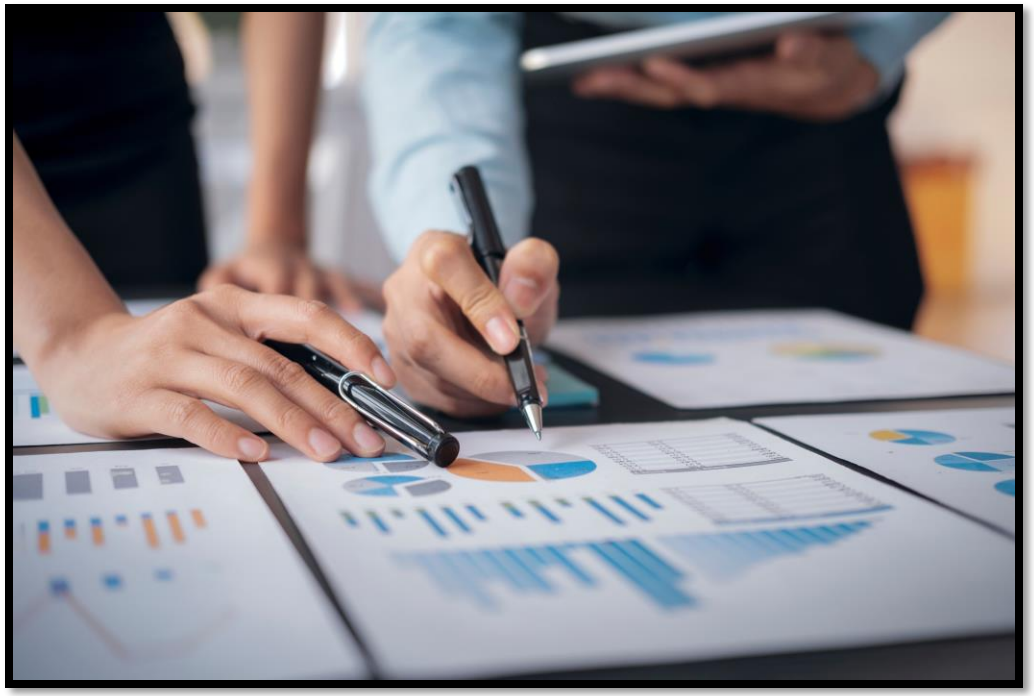
- Have a process to collect and document in the EHR their patient's race, ethnicity, disability, sexual orientation, or gender identity. **
- Meet a benchmark for the proportion of patients with one or more characteristics documented in the EHR.

Patient characteristic	Percent of patients with this documented in the EHR
Race	80%
Ethnicity	80%
Disability	80%
Sexual orientation	50%
Gender identity	50%

** Important note: PCPCHs are required to document language in 4.C.0

PCPCH measure 4.C.2 documentation

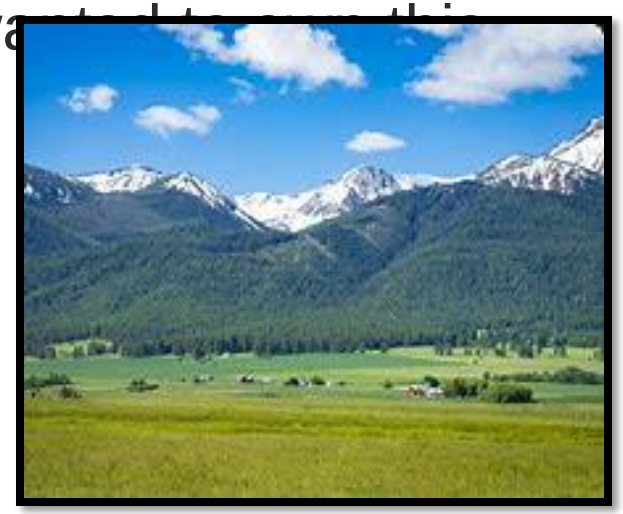
- Policy, procedure or workflow for obtaining and documenting at least one of the patient characteristics above
- Snapshot or example of the form, database, or other mechanism for obtaining this information
- Data used to calculate performance on the benchmark



PCPCH measure 4.C.2 rural implementation strategy

Winding Waters Medical Clinic, a Federally Qualified Health Center (FQHC) in Wallowa County, has a process for collecting SOGI information from their patients.

- We started with the Patient and Family Advisory Committee (PFAC), asking about their level of comfort volunteering this information
- To facilitate trust and engagement, the rooming staff wa[illegible] process
- Scripting and practice helped the staff prepare.
- PDSA cycles helped us to fine tune our process



PCPCH measure 5.B.3

Helping patients navigate their health care costs

PCPCH standard 5.B. Health care cost navigation

Measures

Check all that apply – Select all levels that describe your practices activities. (max 20 pts)

5.B.1 - PCPCH informs their patients of preventive services that do not require cost-sharing. (5 points)

5.B.3 - PCPCH assists its patients in navigating the cost and payment options for their care. (15 points)

PCPCH measure 5.B.3 intent

- Community listening session participants told us **cost is a barrier** to accessing health care services, including primary care. Examples of cost issues patients experience include:
  - Co-payments, high deductibles, and other cost-sharing.
  - Being uninformed about which services are covered by insurance.
  - Specialists, medications, and treatments recommended by their provider.

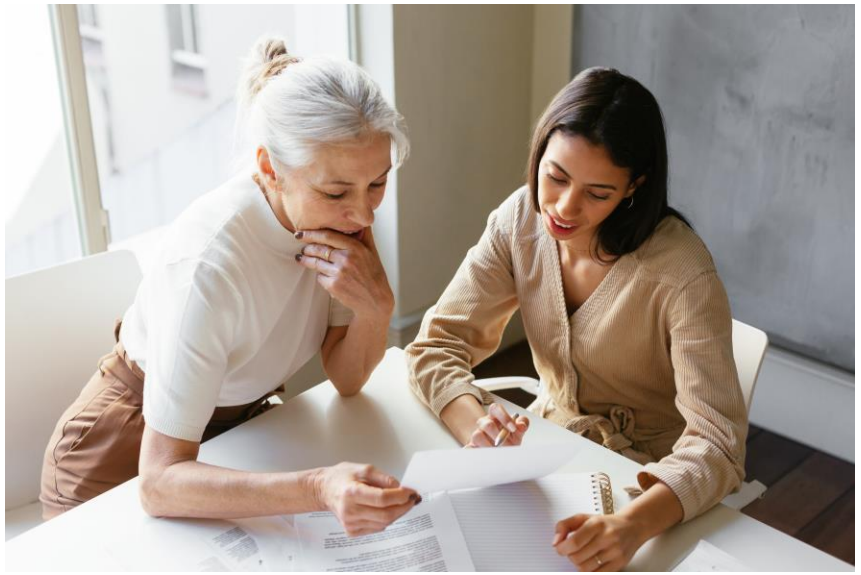
- PCPCHs can help reduce these barriers by increasing price transparency and helping patients navigate their payment options

PCPCH measure 5.B.3 specifications

- A PCPCH must provide at **least one** cost coordination service for its patients. Examples include providing patients with:
  - Price transparency or generalized out-of-pocket cost estimates for services provided at the practice
  - Diagnosis codes and CPT codes or official names of internal services that they can use to acquire cost estimates
  - Individual patients with estimates of how much a prescribed medication will cost them specifically based on their plan
  - Estimates of how much a visit, service, test, or treatment at the practice will cost them based on their specific health plan

PCPCH measure 5.B.3 documentation

- Evidence demonstrating the type(s) of cost navigation services provided, such as:
  - Written policy, procedure, or workflow
  - EHR tool
  - Webpage
  - Poster
  - Patient materials
  - Evidence of other communication channels



PCPCH measure 5.B.3 rural implementation strategy

A rural PCPCH in Central Oregon provides information about out-of-pocket costs to patients having MRI, CT, or other advanced imaging. Their process includes:

- Contacting the imaging facility to get more information about the costs
- Contacting the patient's insurance provider to ask about:
  - Coverage for imagining
  - Is the deductible met
  - Out-of-pocket total expenses
- Sharing this cost information with the patient in plain language so they understand what are their costs

PCPCH measure 6.E.3

Partnering with traditional health workers

PCPCH standard 6.E Cultural responsiveness of workforce

Measures

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 (THW) or traditional health worker services. (15 points)

PCPCH standard 6.E.3 intent

- Community listening session participants described how Traditional Health Workers (THW) and Community Health Workers (CHW) bridge gaps in trust, culture, and language between primary care and patients from underserved populations.

- The intent of this standard is for PCPCHs to take steps to understand their patient population and deliver care in a way that is culturally responsive, trauma-informed, and improves overall trust.

PCPCH measure 6.E.3 specifications

A practice is meeting measure 6.E.3 if it partners with one or more THWs or THW services in delivering care to patients. THW types are:

- Community Health Workers
- Personal Health Navigators
- Birth Doulas
- Peer Support Specialists (including Family Support Specialists, Recovery Peers, and Mental Health Peers)
- Youth Support Specialists
- Peer Wellness Specialists, or other similar roles

PCPCH measure 6.E.3 rural implementation strategy

How a **Personal Health Navigator** can improve care for your patients

- A patient in your practice is suffering from gastrointestinal issues for more than six months
- Your patient's primary language is not English, and this is a barrier to understanding diagnostic exams, treatment options, and general communication
- Your patient refuses diagnostic exams because she doesn't trust specialists and the diagnostic process, however your patient is suffering and her symptoms are getting worse
- Your practice has a Personal Health Navigator work with your patient and her family to address barriers and build rapport and trust in her medical team

More information and resources

2025 PCPCH Recognition Criteria Technical Specifications and Reporting Guide (TA Guide) Link to TA Guide

PCPCH TA Resources Additional technical assistance resources including templates, recorded webinars, white papers, and protocols are on the PCPCH TA Resource webpage

PCPCH Program Health Equity Initiative Community Engagement Report (community listening sessions) Link to report

Oregon Health Authority Strategic Plan 2024-2027 Link to plan

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Thank you

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