Oregon's Primary Care Transformation Initiative

2020 Progress Report

Primary Care Payment Reform Collaborative

May 2021

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Executive Summary

The Primary Care Payment Reform Collaborative ("Collaborative") is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA).[1] The Collaborative advises and assists OHA in implementing the Primary Care Transformation Initiative ("Initiative") to:

- Use value-based payment (VBP) methods to increase investment in primary care, align primary care reimbursement, and improve reimbursement methods, including by investing in the social determinants of health and
- Facilitate the integration of primary care behavioral and physical health care.

The legislation directs the Collaborative to develop strategies that support the implementation of the Initiative, including the provision of technical assistance; the aggregation of data and alignment of metrics; and evaluation of the Initiative. The Collaborative includes 42 members representing a range of providers, payers and other primary care stakeholders. This annual report reviews the Collaborative's work in 2020 and outlines next steps for making progress in 2021.

The COVID-19 pandemic greatly impacted the members and work of the Collaborative. The group canceled one of its quarterly meetings to allow members to focus on pandemic response. When the Collaborative reconvened in July, members discussed the impact of COVID on primary care and the role of payment on practice sustainability. A survey fielded weekly since March 2020 by the Larry A. Green Center found that roughly 70% of primary care providers in Oregon saw patient volume decrease by more than half.[2] An early analysis of primary care practices across the country shows positive impact of value-based payment (VBP) models. [3]

In light of the pandemic's disproportionate impact on communities of color and renewed attention to racial justice, the Collaborative explored how primary care payment reform could address health disparities. Collaborative members shared practice-level activities to incorporate equity at the clinic-level and discussed how payment reform could support this work focusing on three opportunities: 1) implementing payment models to support traditional health workers (THWs), 2) incorporating equity more explicitly into the Patient-Centered Primary Care Home (PCPCH) Program, and 3) supporting the collection of race, ethnicity, language and disability data.

In order to facilitate increased use of VBPs, the Collaborative recommended that the Patient-Centered Primary Care Home (PCPCH) Program share clinic attestation information with payers that can help identify practices that may be ready for value-based payment and can be a starting point for discussions with PCPCHs. This sharing began in November 2020.

The past year also saw increased attention to the role of VBPs to improve quality and reduce cost. The Collaborative is coordinating with several statewide initiatives to support VBPs -- the Sustainable Health Care

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[1] Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017].

[2] Impacts of COVID-19 on Oregon Primary Care Providers: Survey Highlights. https://www.oregon.gov/oha/FOD/Documents/PCP-Survey-Summary.pdf

[3] "Leveraging Payment Reforms For COVID-19 And Beyond: Recommendations For Medicare ACOs And CMS's Interim Final Rule, " Health Affairs Blog, May 29, 2020. DOI: 10.1377/hblog20200528.402208 https://www.healthaffairs.org/do/10.1377/hblog20200528.402208/full/

Cost Growth Target Program, the Oregon VBP Compact, Coordinated Care Organization (CCO) 2.0 and the Universal Access to Primary Care Work Group.

In 2021, the Collaborative will finalize primary care payment reform recommendations to increase health equity that will be informed by, and developed in partnership with, the OHA Office of Equity and Inclusion, the Traditional Health Worker Commission and the PCPCH Program. The Collaborative also will continue to align with other VBP initiatives, promoting opportunities for primary care payment reform to improve quality, increase health and lower costs.

Introduction

The Primary Care Payment Reform Collaborative ("Collaborative") is a legislatively mandated multi-stakeholder advisory body to the Oregon Health Authority (OHA)[4]. The Collaborative advises and assists OHA in implementing a Primary Care Transformation Initiative ("Initiative") to:

- Use value-based payment (VBP) methods that are not paid on a per-claim basis to:
    - Increase the investment in primary care,
    - Align primary care reimbursement by all purchasers of care, and
    - Continue to improve reimbursement methods, including by investing in the social determinants of health;
- Increase investment in primary care without increasing costs to consumers or increasing the total cost of health care; and
- Facilitate the integration of primary care behavioral and physical health care.

The legislation directs the Collaborative to support the implementation of the Initiative through the following strategies:

- Provide technical assistance to clinics and payers in implementing the Initiative;
- Aggregate the data from and align the metrics used in the Initiative with the work of the Health Plan Quality Metrics Committee; and
- Evaluate whether the goals of the Initiative were met by December 31, 2027.

The COVID-19 pandemic greatly impacted the members and work of the Collaborative. The Collaborative meets quarterly; however, the April 2020 Collaborative meeting was cancelled to allow members to focus on pandemic response. The disproportionate impact of the pandemic on communities of color motivated heightened focus on the role of primary care payment reform to improve health equity when the group reconvened in July. The Collaborative also expanded the scope of its work to focus on alignment with the Sustainable Health Care Cost Growth Target Program.

The Collaborative includes 42 members representing a broad range of provider, payer and other primary care stakeholders; membership categories are defined in statute. The list of members is in Appendix A and details about the Collaborative's process and work are in the group's charter in Appendix B. The Collaborative's Implementation and Technical Assistance work group met regularly in between Collaborative meetings to identify:

[4] Chapter 575 Oregon Laws; Senate Bill [SB] 934 [2017].

1. Strategies to share Patience-Centered Primary Care Home attestation information that could help payers identify practices that may be ready for value-based payment and would offer a starting point for discussions with PCPCHs; and
2. Opportunities to increase health equity through payment reform.

This report reviews the Collaborative's work in 2020 and outlines steps for making progress in 2021.

COVID Impact and Role of Payment on Practice Sustainability

The COVID-19 pandemic brought enormous upheaval to primary care patient volume, finances and care delivery methods. According to a survey fielded weekly since March 2020 by the Larry A. Green Center in partnership with the Primary Care Collaborative, roughly 70% of primary care providers in Oregon saw patient volume decrease by more than half; at one point nearly half of primary care providers surveyed in Oregon were laying off or furloughing staff.[5]

An early analysis of the impact of VBPs on primary care practices across the country shows that VBPs allowed some primary care practices to redesign their workflow, offer needed services and approaches in response to the pandemic, and leverage the competencies and infrastructure built through VBP support. For example, practices have re-purposed care coordinators for testing and tracking, used their population health management data systems to identify high-risk patients, and/or utilized telehealth and in-home services to provide chronic care services. Primary care practices with prospectively paid, risk-adjusted per member per month VBP arrangements in place prior to the pandemic have been better able to adapt to challenges and meet the needs of their patients and communities. By decoupling payment from the delivery of specific services, practices had the flexibility to innovate quickly without fear of financial impact.[6]

The success of prospectively paid VBP models in protecting the financial stability of practices and controlling cost and improving quality are supporting payers' and practices' interest in shifting to VBP. Whether this will lead to an increase in VBP adoption is not yet known.

Role of Payment Reform Strategies to Increase Health Equity

In light of the pandemic's disproportionate impact on communities of color and renewed attention to racial justice, the Collaborative explored how primary care payment reform could address health disparities. The Collaborative recognizes that to improve health across all populations it is critical to sustain and reward high-quality, equitable health care designed to eliminate health inequities. At its October 21, 2020 Collaborative meeting, Collaborative members presented practice-level activities that incorporate equity at the clinic-level. These efforts include:

- Collecting race, ethnicity, language and disability (REALD) data
- Screening for health-related social needs and providing resources and navigation to address identified needs

[5] Impacts of COVID-19 on Oregon Primary Care Providers: Survey Highlights. https://www.oregon.gov/oha/FOD/Documents/PCP-Survey-Summary.pdf

[6] "Leveraging Payment Reforms For COVID-19 And Beyond: Recommendations For Medicare ACOs And CMS's Interim Final Rule, " Health Affairs Blog, May 29, 2020. DOI: 10.1377/hblog20200528.402208 https://www.healthaffairs.org/do/10.1377/hblog20200528.402208/full/

- Communicating in a manner that works for patients, including providing materials in relevant languages and interpreters
- Integrating behavioral health and oral health to provide whole-person care
- Including diverse providers on care teams, such as Traditional Health Workers (THWs)
- Creating senior leadership position(s) focused on equity and inclusion
- Increasing the diversity of health care providers
- Providing culturally and linguistically responsive case management services
- Providing training, resources and tools on anti-racism, such as scripting for staff to address racist comments
- Implementing a process to identify racial and structural inequities; social determinants of health needs; and gaps in care, services, and health outcomes. This could include use of racial equity assessment tools, practice-level sociodemographic reports, disaggregated practice quality metrics reports and development and implementation of health inequity solutions.

After learning about these activities, the Collaborative turned its attention to discussing how payment could incentivize and support focused attention to reducing disparities. All Collaborative members were invited to continue discussing opportunities to incorporate health equity at the December 8, 2020 Implementation and Technical Assistance Workgroup meeting. Participants reviewed the strategies presented by Collaborative members as well as additional approaches identified by OHA staff through policy research. The Collaborative identified three potential opportunities for additional discussion in 2021:

- Implement payment models, such as VBPs or increased payment rates, to sustainably support THWs
- Incorporate equity more explicitly into the Patient-Centered Primary Care Home (PCPCH) Program by adding:
    - Provider distinction or certification to identify organizations that lead by providing culturally and linguistically sensitive services and working to reduce health care disparities
    - A standard with specific definitions and measurement criteria for equity-focused trainings, such as anti-racism and culturally responsive care
- Simplify and support the collection of REALD data through:
    - Identification of a central mechanism to collect data
    - Implementation of patient education strategies to introduce the REALD form and importance of collecting the data
    - Implementation of a payment model to support the full cost of data collection practices incur

In 2021, the Collaborative will finalize recommendations that will be informed by and developed with the OHA Office of Equity and Inclusion, the Traditional Health Worker Commission and the PCPCH Program.

Alignment with Other Value-based Payment (VBP) Activity

The VBP landscape in Oregon is evolving and the Collaborative is working to align with other initiatives including the Sustainable Health Care Cost Growth Target Program and the VBP Compact; Coordinated Care Organization (CCO) 2.0; and the Universal Access to Primary Care Workgroup.

- **Sustainable Health Care Cost Growth Target Program:** The Oregon Legislature through Senate Bill 889 (2019 Laws) established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority. A health care cost growth target will serve as a target for the annual per capita rate of growth of total health care spending in the state. Cost increases of health insurance companies and health care providers will be compared to the growth target each year. The program will also evaluate and annually report on cost increases and drivers of health care costs. In 2019, the legislature created the Sustainable Health Care Cost Growth Target Implementation Committee (Implementation Committee) and charged it with identifying mechanisms to lower the growth of health care spending in Oregon to a financially sustainable rate.
- **Oregon VBP Compact:** The Implementation Committee identified VBP as a key mechanism to lower the growth of health care spending and developed a set of principles to increase the spread of VBP models across the state. The first principle calls on the Implementation Committee, plus representatives of other larger insurer, purchaser and provider organizations in the state, to develop a voluntary compact to achieve the spread of VBP models. The Oregon VBP Compact is a commitment by payers and providers to participate in and spread VBPs, meeting specified targets and timelines over the next four years. The Compact is jointly sponsored by OHA and the Oregon Health Leadership Council.
- **CCO 2.0:** On Jan. 1, 2020, new contracts launched for Oregon's 15 coordinated care organizations (CCOs) that set requirements for improving care for Oregon Health Plan (OHP) members, including VBP targets to ensure at least 70% of their payments to providers are in the form of a VBP by 2024. Additionally, CCOs are required to provide per-member-per-month (PMPM) payments to their Patient-Centered Primary Care Home (PCPCH) clinics at meaningful amounts, that vary by tier and increase each year over the five-year contract. Although these payments do not link to quality, they increase primary care spend and can be combined with quality-based payment models, such as pay-for-performance, to count towards the VBP target.
- **Universal Access to Primary Care Work Group:** In January 2020, the House Committee on Health Care created the Universal Access to Primary Care (UAPC) Work Group led by Representatives Prusak and Moore-Green. The work group is comprised of twenty members who represent a wide-ranging set of primary care stakeholders, including primary care practitioners, behavioral health specialists, specialty providers, health system representatives, CCOs, payers, and a patient advocate. The Work Group was tasked with developing proposals to move Oregon toward universal access to comprehensive primary care, based on available data and building on the body of existing research and current state reform initiatives. In December 2020, the Work Group issued recommendations to 1) increase access to and affordability of comprehensive primary care, 2) increase support for and participation in Oregon's PCPCH model, 3) remove barriers to telehealth, and 4) advance alternative payment models across payers.

Sharing Patient-Centered Primary Care Home (PCPCH) Attestation Information to Promote VBP

Primary care practices participating in Oregon's PCPCH Program have certain capabilities or are conducting activities that support their readiness to participate in VBP models. PCPCH recognition is based on 34 standards across core attributes of access to care, accountability, comprehensive, continuity, coordination and integration, and patient and family-centeredness. (See Exhibit C for the list of standards.) Every two years on a rolling basis, PCPCHs are recognized at one of five tier levels based on their attestation to the standards.

For the past seven years, the PCPCH program has published a password-protected Excel spreadsheet of PCPCHs for payers to download from the PCPCH website each month. Information on the list includes a PCPCH's location, National Provider Identifier and Tax Identification Number, contacts, tier level attested to, points attested to, history of tier levels and applications dates, practices that are no longer recognized, and notes from the program to payers about a practice (for example, if the practice merged with another practice).

At the recommendation of the Collaborative, in November 2020 the PCPCH Program added the PCPCH recognition standard measures attested to by practices to the Excel spreadsheet. Collaborative members felt that this additional information could help payers identify practices that may be ready for value-based payment and would offer a starting point for discussions with PCPCHs. PCPCHs have been informed of this change via email from the PCPCH Program.

Next Steps

In 2021, the Collaborative will finalize primary care payment reform recommendations to increase health equity that will be informed by, and developed in partnership with, the OHA Office of Equity and Inclusion, the Traditional Health Worker Commission and the PCPCH Program. The Collaborative also will continue to align with other VBP initiatives, promoting opportunities for primary care payment reform to improve quality, increase health and lower costs.

Appendix A: Primary Care Payment Reform Collaborative Members

- Carolyn Anderson, Clinical Quality Director, Mountain View Medical Center
- Gary Ashby, Health Insurance Specialist, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
- Beth Black, Employee Benefit Consultant, Hagan Hamilton Insurance Solutions
- Tanveer Bokhari, VP, Quality & Health Equity, Umpqua Health Alliance*
- Bill Bouska, Director of Community Solutions and Government Affairs, Samaritan Health Plans, InterCommunity Health Network CCO
- Will Brake, Chief Operating Officer, AllCare Health
- Damian Brayko, Deputy Director, Public Employees' Benefit Board & Oregon Educators Benefit Board
- Joy Conklin, Vice President of Practice Advocacy, Oregon Medical Association
- Dawn Creach, Health Care Consultant, Creach Consulting, LLC
- Larlene Dunsmuir, Assistant Executive Director for Professional Services, Oregon Nurses Association
- Bill Dwyer, Director of Analytics, Moda Health and Eastern Oregon CCO
- Eleanor Escafi, Assistant Director of Strategy and Execution, Network Management/Provider Partnership Innovation, Regence BlueCross BlueShield of Oregon & Cambia Health Solutions
- Amy Hill, VP, Provider and Network Management, Health Net Health Plan of Oregon Inc. and Trillium Community Health Plan*
- Kevin Ferrua, Senior Financial & Contract Analyst, Yamhill Community Care
- Scott Fields, Chief Medical Officer/Chief Informatics Officer, OCHIN
- Tanveer Bokhari, VP, Quality & Health Equity, Umpqua Health Alliance
- Maribeth Guarino, High Value Care Associate, OSPIRG*
- Robin Henderson, Chief Executive of Behavioral Health, Providence
- Kristan Jeannis, Quality Improvement Coordinator, Tuality Health Alliance
- Jen Johnstun, Chief Quality Officer, Siskiyou Community Health Center (previously at Primary Health)
- Mary Kjemperud, Director of Network and Clinical Support, Jackson Care Connect and CareOregon
- Lisa Ladd, Director of Contracting & Provider Network, WVP Health Authority
- Cat Livingston, Medical Director, Health Share of Oregon*
- Doug Lincoln, Pediatrician, Metropolitan Pediatrics
- Lynnea Lindsey, Director of Behavioral Health Services, Legacy Health
- Barbara Martin, Director of Primary Care, Central City Concern
- Ben Messner, Chief Executive Officer, Advanced Health
- Justin Montoya, Medical Director of Commercial Programs, PacificSource Health Plans
- Liz Powers, Physician, Winding Waters Clinic
- Colleen Reuland, Director, Oregon Pediatric Improvement Partnership
- Deborah Rumsey, Executive Director, Children's Health Alliance
- Divya Sharma, Medical Director, Central Oregon Independent Practice Association
- Christa Shively, Senior Director of Quality and Medical Integration, Providence Health Plans
- Christi Siedlecki, Chief Executive Officer, Grants Pass Clinic
- Colleen Smith, Senior Manager of Client Services, Mental Health, Family Health, Network and Housing Services, Willamette Family, Inc.
- Martha Snow, Project Manager, Oregon Rural Practice-based Research Network*
- Danielle Sobel, Policy Director, Oregon Primary Care Association
- Rebecca Tiel, Director of Public Policy, Oregon Association of Hospitals and Health Systems
- Megan Viehmann, Pharmacist, OHSU Family Medicine at Richmond

- Khalid Wahab, Senior Engagement Manager, Aetna
- Rick Williams, Physician, Oregon Academy of Family Physicians*
- Charles Wilson, General Counsel, ATRIO Health Plans
- Gayle Woods, Senior Policy Advisor, Oregon Department of Consumer and Business Services

Oregon Health Authority staff and consultants

- Diana Bianco, Collaborative Facilitator, Artemis Consulting
- Summer Boslaugh, Transformation Analyst, Oregon Health Authority Transformation Center
- Tom Cogswell, Project Coordinator, Oregon Health Authority Transformation Center
- Chris DeMars, Director, Oregon Health Authority Transformation Center and Deputy Director, Delivery Systems Innovation Office
- Amy Harris, Manager, Patient-Centered Primary Care Home Program, Oregon Health Authority Transformation Center

* New member in 2020

Appendix B: Primary Care Payment Reform Collaborative 2021 Charter[1]

I. Authority

Oregon is required by statute (Chapter 575 Oregon Laws) to convene a Primary Care Payment Reform Collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative. The purpose of the Initiative is to develop and share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments toward supporting and facilitating health care innovation and care improvement in primary care. Senate Bill 934 (2017) states that the Initiative should:

- Increase investment in primary care (without increasing costs to consumers or increasing the total cost of health care);
- Improve reimbursement methods, including by investing in the social determinants of health; and
- Align primary care reimbursement by purchasers of care.

To achieve the implementation of this Initiative, the Collaborative will support:

- Use of value-based payment methods;
- Incorporation of health equity into primary care payment reform;
- Provision of technical assistance to clinics and payers in implementing the initiative;
- Aggregation of data across payers and providers;
- Alignment of metrics, in concert with work of the Health Plan Quality Metrics Committee established in ORS 413.017; and
- Facilitation of the integration of primary care behavioral and physical health care.

II. Deliverables

Senate Bill 934 (2017) requires the Collaborative to report annually to the Oregon Health Policy Board (OHBP) and the Oregon Legislature on the implementation of the Primary Care Transformation Initiative and progress toward meeting primary care spending targets. The third progress report will be delivered by April 1, 2020. The goals of the Initiative will be met by 2027.

The Collaborative has combined the Implementation and Technical Assistance work groups, convened in 2019, into one work group to move the Initiative forward in 2021. This group will meet regularly in between Collaborative meetings to identify:

3. Strategies to support implementation of payment models in the Initiative including attribution, data aggregation and reporting; and
4. Technical assistance (TA) resources to support implementation of the Initiative payment models, including leveraging existing TA resources.

[1] This charter has been updated slightly to reflect recent changes in the Collaborative's (1) work group structure; (2) focus on promoting health equity; and (3) intention to align with Sustainable Health Care Cost Growth Target Program. The updated charter will be shared with the Collaborative members for approval at the next meeting in April 2021.

The Collaborative is focused on primary care transformation and reimbursement. Specialty care and inpatient hospital services are not within the scope, except to the extent to which that these topics impact the goals of the Initiative.

The Collaborative is committed to coordinating and aligning with related initiatives including, but not limited to, Comprehensive Primary Care Plus (CPC+), Health Plan Quality Metrics Committee, the Patient-Centered Primary Care Home Program and the Sustainable Health Care Cost Growth Target Program.

III. Dependencies

To the extent directed and supported by OHA, the Committee will coordinate its recommendations to align with national and state health policy initiatives in formal reports submitted to:

- OHA Leadership
- Oregon Health Policy Board
- Oregon Legislature

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

IV. Membership

In accordance with Chapter 575 Oregon Law, Collaborative membership includes representatives from the following entities:

- Primary care providers
- Health care consumers
- Experts in primary care contracting and reimbursement
- Independent practice associations
- Behavioral health treatment providers
- Third party administrators
- Employers that offer self-insured health benefit plans
- The Department of Consumer and Business Services
- Carriers
- A statewide organization for mental health professionals who provide primary care
- A statewide organization representing federally qualified health centers
- A statewide organization representing hospitals and health systems
- A statewide professional association for family physicians
- A statewide professional association for physicians
- A statewide professional association for nurses
- The Centers for Medicare and Medicaid Services

Additional members may be invited to participate based on their experience and knowledge of primary care. Collaborative member terms are for a minimum of two years, with up to six meetings per year.

V. Resources

Internal staff resources include the following:

- Executive Sponsors: OHA Health Policy & Analytics Division Director; OHA Chief Medical Officer
- Staff support:
    - Health Policy and Analytics Division, Transformation Center (lead)
    - Health Systems Division
    - External Relations Division

Appendix C: Patient-Centered Primary Care Home Recognition Standards

The table below lists the 2020 PCPCH recognition standards that were implemented in early 2021. Written descriptions of each measure are in the PCPCH Recognition Criteria Technical Specifications and Reporting Guide.

Oregon PCPCH 2020 Standards
Standard 1.A: In-Person Access 1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams. 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.
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.
Standard 1.C: Telephone & Electronic Access 1.C.0 PCPCH provides continuous access to clinical advice by telephone.
Standard 1.D: Same Day Access 1.D.1 PCPCH provides same day appointments.
Standard 1.F: Prescription Refills 1.F.2 PCPCH tracks the time to completion for prescription refills. 1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.
Standard 1.G: Alternative Access 1.G.1 PCPCH regularly communicates with patients through a patient portal. 1.G.2 PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.
Standard 2.A: Performance & Clinical Quality 2.A.0 PCPCH tracks and reports to the OHA three measures from the set of PCPCH Quality Measures. 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. 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.
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.

Oregon PCPCH 2020 Standards
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. 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. 2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.
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. 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 document their progress. 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.
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. 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. 2.E.3 PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure.
Standard 2.F: PCPCH Staff Vitality 2.F.1 PCPCH uses a structured process to identify opportunities to improve the vitality of its staff. 2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.
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. 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. 3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.

Oregon PCPCH 2020 Standards
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.
Standard 3.C: Behavioral Health Services 3.C.0 PCPCH has a screening strategy for mental health, substance use, and developmental conditions, and documents on-site and local referral resources and processes. 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. 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. 3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.
Standard 3.D: Comprehensive Health Assessment & Intervention 3.D.1 PCPCH has a routine assessment to identify health-related social needs in their patient population. 3.D.2 PCPCH tracks referrals to community-based agencies for patients with health-related social needs. 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.
Standard 3.E: Preventive Service Reminders 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. 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.
Standard 3.F: Oral Health Services 3.F.1 PCPCH utilizes a screening and/or assessment strategy for oral health needs. 3.F.2 PCPCH utilizes a screening and or/assessment strategy for oral health needs and provides age-appropriate interventions. 3.F.3 PCPCH provides oral health services by dental providers.
Standard 4.A: Personal Clinician Assigned 4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team. 4.A.3 PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team.

Oregon PCPCH 2020 Standards
Standard 4.B: Personal Clinician Continuity 4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. 4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. 4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.
Standard 4.C: Organization of Clinical Information 4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the Centers for Medicare and Medicaid Services 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.
Standard 4.D: Clinical Information Exchange 4.D.2 PCPCH exchanges clinical information electronically to another provider or setting of care. 4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).
Standard 4.E: Specialized Care Setting Transitions 4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.
Standard 4.F: Planning for Continuity 4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills and clinical questions when a provider is not available.
Standard 4.G: Medication Reconciliation and Management 4.G.2 PCPCH has a process for medication reconciliation for patients with complex or high-risk medication concerns. 4.G.3 PCPCH provides Medication Management for patients with complex or high-risk medication concerns.
Standard 5.A: Population Data Management 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.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.
Standard 5.C: Care Planning 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. 5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of diverse patients with complex care needs. 5.C.3 PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns.

Oregon PCPCH 2020 Standards
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, families, or caregivers as well as to ordering clinicians.
Standard 5.E: Referral & Specialty Care Coordination 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.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care specialized settings (hospital, SNF, long term care facility). 5.E.3 PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social service, foster care (either adult or child), public health, traditional health workers, school-based health center, behavioral health providers and organizations, and pharmacy services.
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. 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.
Standard 6.A: Meeting Language and Cultural Needs 6.A.0 PCPCH offers time-of-service translation to communicate with patients, families, or caregivers in their language of choice. 6.A.1 PCPCH provides written patient materials in non-English languages spoken by populations served at the clinic.
Standard 6.B: Education & Self-Management Support 6.B.1 PCPCH provides patient-specific education resources to their patient population. 6.B.2 PCPCH provides patient-specific education resources and offers self-management support resources to their patient population. 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.
Standard 6.C: Experience of Care 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. 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. 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).

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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).
Standard 6.D: Communication of Rights, Roles and Responsibilities 6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient, family, or caregiver receives this information at the onset of the care relationship.