Summary of Version 4 of the PCPCH 2025 Technical Assistance Guide

In 2026 the Patient-Centered Primary Care Home (PCPCH) Program made several operational changes to reduce the administrative burden for participating clinics. This work included:

- Updating the technical specifications for certain measures to align more closely with current clinic operations, reduce administrative burden and make some measures easier to meet; and
- Revising the PCPCH 2025 Recognition Criteria Technical Specification and Reporting Guide (TA Guide) format for clarity and to reduce overall length.

This document contains a summary of the updates and revisions that are included in **Version 4** of the TA Guide, which was published in November of 2026.

Updates to eligibility requirements

Any clinic that has been operating for six months or longer can now apply for PCPCH recognition. Previously, clinics had to be operating for 12 months or longer.

Updates to TA Guide format

The TA Guide content and specifications have been condensed/summarized, resulting in a shorter document and less required reading. Each measure's specifications are now organized into the following three sections:

Measure Specifications: What is required for each clinic that attests to a particular measure within the standard.

Documentation required at a Verification Site Visit: The information that a clinic would need to provide to verify that they are meeting the specifications for that measure if they were selected for a PCPCH verification site visit.

Additional Tips or Resources: Helpful information and suggestions that, while not required to attest to a particular measure, may be helpful for clinics interested in exploring it in more depth.

Clinics interested in additional ideas can refer to the supplementary resource PCPCH Measure Implementation Examples if desired, but this is not required reading as all relevant information is still included in the TA Guide.

Updates to documentation required at a verification site visit

Standard 2.A – Performance and Clinical Quality: Clinics are no longer required to provide the original measure source/steward or the full specifications as part of their documentation. Instead, clinics can provide the title of each quality measure and a brief description of what is included in the numerator and denominator.

Measure 3.C.2.a – Behavioral Health Services: Clarified that documentation should focus on evidence of *cooperative* referrals as described in the specifications.

Measure 4.A.0 – Personal Clinician Assignment & Continuity: Clinics with only one primary care provider are now exempt from having to provide assignment/continuity data.

Measure 4.B.3 – Medication Reconciliation and Management: Condensed the elements that need to be included in chart note examples of comprehensive medication management.

Measures 5.A.2 and 5.A.3 – Population Data Management: Broadened documentation item # 2 to include any evidence that all patients at the clinic are assigned a risk score.

Measure 5.C.2 – Complex Care Coordination: Condensed required documentation into two items instead of three.

Measure 6.E.0 – Cultural Responsiveness of Workforce: No longer requires documentation (will be verified via interview questions during a site visit).

Updates to documentation required during a health equity review

Measure 1.G.1 – Alternative Access: Clarified that chart note example must include evidence that interpretation services were used or available during the telehealth appointment.

Additional updates to standards and measures

Standard 1.C.0 – Telephone Access:

- Clarified that clinics with only one primary care provider must be able to demonstrate that their patients can reach a live person for medical advice when they are unavailable (e.g. sleeping, ill, on vacation, etc.).
- Clarified that phone calls should be documented in EHR within 48 hours of the call.

Standard 1.F.3 – Prescription Refills: Revised so that clinics can demonstrate reaching the benchmark over the last 6 months (instead of 12 months) if preferred.

Standard 2.A – Performance & Clinical Quality:

- Revised so that clinics are no longer required to use the same three quality measures for 2.A.0, 2.A.1, 2.A.2, and 2.A.3 (but can still choose to if preferred).
- Updated "Qualifying Primary Care Quality Measure Lists" on page 32.
- **Measure 2.A.2:** Now includes additional guidance for finding free benchmarks, along with a link to a new supplemental resource: Benchmarks for PCPCH Measure 2.A.2.
- **Measure 2.A.3:** Clarified that there is not a minimum number of patients required in the denominator to demonstrate improvement on a disparity for that subgroup.

Standard 2.B – Value Based Payment: Simplified measure language and clarified which HCP-LAN category is most relevant to Measure 2.B.2.

Standard 3.A – Preventive Services:

- Updated the list of Recommended Age- and Sex-Specific Preventive Services (see pg. 53).
- **Measure 3.A.3:** Updated the list of preventive services included in Table 3.A and the PCPCH Standard 3.A.3 Calculation Tool.

Measure 3.B.0 – Medical Services:

- Clarified that clinics do not need to engage in comprehensive closed-loop referral tracking for recommended vaccines that they do not provide onsite, but must still coordinate patient access to these services in some way.
- Updated links to recommended vaccines to include those supported by the West Coast Health Alliance.

Standard 3.F – Oral Health Services: Revised so that clinics only need to screen/assess the oral health needs and provide interventions for children or priority population(s). Clinics can still screen and provide interventions for their entire patient population if preferred, but this is no longer required (see U.S. Preventive Services Task Force Recommendations around lack of sufficient evidence for routine screening and interventions among general adults).

Measure 5.C.3 – Complex Care Coordination:

- Revised so that care plans only need to include patient-specific short-term health goals, long-term health goals, and an action plan to qualify for this measure. Clinics should still consider incorporating additional elements that would be beneficial to individual patients.
- Removed requirement that a patient's decision to decline a care plan must be documented in their chart.

Measure 5.A.2 – Population Data Management: Clarified that clinics do not need to manually review and update patients' risk scores if their Electronic Health Record or risk score software regularly updates the scores in response to changes in patients' risk factors or conditions.

Measure 5.E.3 – Referral and Care Coordination with Specialists, Care Facilities and Government Systems: Updated terminology in measure language (see definition of "carceral settings" in footnote 32).

Measure 6.C.2 – Experience of Care:

- Clarified that clinics must incorporate 2 or more equity-related questions into their survey methodology.
- Clarified that clinics using the standard CAHPS survey tools (i.e. the general CAHPS Clinician & Group Survey or the CAHPS PCMH Survey) must either incorporate additional supplemental CAHPS questions related to health equity or administer their own equity-related survey/questions (i.e. the standard CAHPS survey alone does not meet this measure).
- Clarified that clinics using a separate health equity survey must still meet the 3% per-provider response rate for that survey or demonstrate a plan to reach it.

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