OREGON HEALTH AUTHORITY

Health Policy and Analytics

Patient-Centered Primary Care Home Program

PCPCH measure verification changes

In 2026 the Patient-Centered Primary Care Home (PCPCH) Program is making changes to the documentation that a PCPCH is required to provide during a verification site visit from the program. The intent of this change is to reduce administrative complexity for primary care clinics participating in the program.

What's changing

For 38 out of the 84 measures in the PCPCH model, the documentation required has been either reduced (15 measures) or removed completely (23 measures). About 45% of total measures are impacted by this change. The 23 measures for which required documentation was removed will be verified during the site visit by interview or using information on the clinic's PCPCH application.

What's not changing

PCPCH standards and measures remain unchanged. Practices are still expected to meet the measures attested to in their application as described in the PCPCH 2025 Recognition Criteria Technical Specifications and Reporting Guide. The changes to the documentation requirements do not represent a reduction in expectations, standards, or rigor. The PCPCH Program will continue to assess whether a practice is meeting a measure using a combination of information from their application, interviews and documentation review.

Please see the table on the following pages for more information about impacted measures.

Table: PCPCH Measure Verification Changes

PCPCH Measures	Documentation reduced or revised	Documentation removed
Measure 1.C.0 – PCPCH assures that its patients have continuous access to clinical advice by telephone.	-	Yes
Measure 1.C.1 – PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.	-	Yes
Measure 1.D.1 – PCPCH offers same-day appointments.	-	Yes
Measure 1.E.1 – PCPCH regularly communicates with patients through a patient portal.	-	Yes
Measure 1.G.1 – PCPCH offers telehealth services to its patients in their primary language.	-	Yes
Measure 1.G.2 – PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.	Yes	-
Measures 2.B.1-2.B.3 – PCPCH participates in value-based payment arrangements.	-	Yes
Measure 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.	Yes	-
Measure 3.B.0 – PCPCH routinely offers all required categories of primary care services.	-	Yes
Measure 3.C.0 – PCPCH has a routine assessment to identify patients with mental health, substance use, and developmental conditions, and coordinates their care.	-	Yes

PCPCH Measures	Documentation reduced or revised	Documentation removed
Measure 3.C.2.a – PCPCH collaborates or is co-located and coordinates care with specialty behavioral health providers.	**Yes**	**-**
Measure 3.C.2.b – PCPCH provides pharmacotherapy and recovery support for patients with substance use disorders.	**Yes**	**-**
Measure 3.C.3 – PCPCH provides integrated behavioral health services.	**-**	**Yes**
Measure 3.D.2 – PCPCH has a routine assessment to identify health-related social needs (HRSNs) and refers patients to community-based resources.	**Yes**	**-**
Measure 3.E.1 – PCPCH generates lists of patients who need reminders for preventive services.	**-**	**Yes**
Measure 3.F.1-3. F.3 – PCPCH oral health services measures.	**Yes**	**-**
Measure 4.A.0 – PCPCH reports personal clinician assignment and continuity.	**Yes**	**-**
Measure 4.B.2 – PCPCH provides medication reconciliation for its patients.	**-**	**Yes**
Measure 4.B.3 – PCPCH provides comprehensive medication management by a pharmacist.	**Yes**	**-**
Measure 4.C.0 – PCPCH uses a certified electronic health record.	**-**	**Yes**
Measure 4.C.1 – PCPCH documents patient demographic characteristics in the EHR.	**-**	**Yes**
Measure 4.C.2 – PCPCH meets a benchmark for demographic data completeness.	**Yes**	**-**
Measure 4.D.3 – PCPCH shares clinical information electronically in real time.	**Yes**	**-**

PCPCH Measures	Documentation reduced or revised	Documentation removed
Measure 4.E.0 – PCPCH has a documented process for hospital transitions of care.	-	Yes
Measure 4.E.2 – PCPCH follows up with patients' post-discharge.	-	Yes
Measure 4.F.0 – PCPCH has a process for reassigning administrative and clinical requests.	-	Yes
Measure 5.A.2 – PCPCH stratifies its patient population by health risk.	Yes	-
Measure 5.A.3 – PCPCH stratifies its patient population by health risk and at least one HRSN or demographic category.	Yes	-
Measure 5.C.1 – PCPCH assigns care coordination responsibilities to staff.	-	Yes
Measure 5.E.2 – PCPCH coordinates care for patients in specialized settings.	-	Yes
Measure 5.E.3 – PCPCH coordinates care with public benefit and government systems.	Yes	-
Measure 5.F.0-5. F.1 – PCPCH end-of-life planning measures.	-	Yes
Measure 6.A.0 – PCPCH offers time-of-service interpretation in patients' primary language.	-	Yes
6.E.3 – PCPCH partners with one or more traditional health workers.	Yes	-

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Patient-Centered Primary Care Home Program at pcpch@oha.oregon.gov or 971-269-7806 (voice and text). We accept all relay calls.