Washington State Health Care Authority

Primary Care Practice Recognition

Practice accountabilities and evaluation guide

Introduction

Primary care is the foundation of the health care delivery system. An effective primary care system drives higher quality outcomes at more efficient cost. Recognizing this, the Washington Health Care Authority (HCA) and the state's purchasers, payers, and primary care practice community have developed the Primary Care Transformation Initiative (PCTI). The initiative provides a common framework to grow capacity and improve quality in the state's primary care system by:

- Creating a standardized set of practice accountabilities, a practice recognition process, and a quality framework to support improved equity and health outcomes
- Implementing aligned payment models to give flexibility and incentives for primary care practices to succeed
- Offering practice supports that ensure practices have resources to grow their capability to provide comprehensive primary care
- Aligning purchaser and payer policy to drive the system forward in a focused direction

This document builds on **previous primary care transformation work** by providing a further developed set of practice accountabilities for reference as transformation efforts progress.

Additionally, the Centers for Medicare and Medicaid Services (CMS) has selected Washington to participate in the Making Care Primary (MCP) model. MCP is a complementary effort to Washington's PCTI, expanding the multi-payer approach by bringing Medicare to the table. MCP and PCTI share many components and a common set of goals. HCA and partners aim to maximize the alignment and impact of the two models.

Primary Care Practice Recognition

A critical component of PCTI is the centralized recognition process known as the Primary Care Practice Recognition (PCPR) program. This process will evaluate practices' capabilities across a range of accountabilities.

Based on this evaluation, practices will be assigned a recognition level rating from 1 to 3. This process has several intended outcomes, some which will be realized earlier than others in Washington's transformation journey. Implementation of the recognition process is anticipated to begin fall 2024.

Initial outcomes

- Provide transparency into the capabilities of individual primary care practices and the broader primary care system.
- Help payers decide how to prioritize the supports they will give to practices participating in the model.

Intended future outcomes

- Establish eligibility for participation in different payment models—such as transformation funding, quality payments, and comprehensive care payments—through a single process recognized across participating payers.
- Provide a way for practices to request transformation funding and other supports.

There are ten accountabilities in total listed in the table below. This document outlines the competencies that define each accountability.

Practice accountabilities	
• Whole-person care • A team for every patient • Resource allocation strategy • Behavioral health integration • Patient support	• Care coordination strategy • Expanded access • Culturally attuned care • Health literacy • Data informed performance management

Recognition level determination

To be recognized at a given level, a practice must meet all required elements across all accountabilities. They must also meet a minimum point threshold for each recognition level. Points are assigned to each capacity based on a combination of impact on patient health, administrative burden, and impact on health equity.

There are programs and models that may have many similarities and align with the requirements of the PCPR program. While not identical, the PCPR program provides an abbreviated recognition pathway for practices that have an accepted alternate recognition or accreditation.

Making Care Primary participants

Making Care Primary (MCP) is a primary care model for Medicare beneficiaries from the Centers for Medicare & Medicaid Services (CMS). MCP consists of three progressive tracks designed to transform care and improve outcomes for their patients. For practices participating in MCP, your practice will receive the equivalent recognition level to your current MCP track.

Patient-centered medical homes

There are national organizations that offer PCMH recognition. For practices with PCMH recognition and that meet all three mandatory capacities under the behavioral health integration capacity, will be recognized at level 3.

Whole-person care

Practice is accountable for providing or ensuring access to a full range of primary care services to attributed patients.

Whole-person care: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 1.1.A. **Mandatory for level 1 recognition** Yes: ☒ No: ☐ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice routinely offers all the following categories of services: • Acute care for minor illnesses and injuries, including low complexity behavioral health interventions • Ongoing management of chronic diseases • Office-based procedures[1] and diagnostic tests for adults and as clinically appropriate for children preventive services[2] including but not limited to: a. Recommended immunizations b. Patient education c. Behavioral health screening d. Self-management support

[1] Office-based procedures refers to procedures that can be safely performed outside of an ASC or hospital setting such as the services described here: **Office Based Procedures – Site of Service – Commercial Utilization Review Guideline (uhcprovider.com)**

[2] Preventive services include, at a minimum, all Grade A and B recommendations from the U.S. Preventive Services Task Force. **A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)**

Whole-person care: level 2

Capacity information	Capacity
Identification number 1.2.A. **Mandatory for level 2 recognition** Yes: ☒ No: ☐ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	For services not provided by the practice, the practice has established and documented practices that ensure that when care is referred to a clinician outside of the practice, the receiving physician understands the intent of the referral, the patient returns to primary care, and the specialist will provide their notes in a timely manner on a per person basis.
Identification number 1.2.B. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	For services not provided by the practice, the practice has sufficient relationships with clinicians outside of the practice to ensure patients can access specialty care in a timely manner.
Identification number 1.2.C. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Members of the care team are aware of the established relationships and adhere to expectations.

Whole-person care: level 3

Capacity information	Capacity
Identification number 1.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has integrated physical and behavioral health care as demonstrated by satisfying competency 4.3.A.

A team for every patient

Attributed patients are assigned to primary care team (empaneled) for evaluation, treatment, and ongoing management. The primary care team may or may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team.

A team for every patient: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 2.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Care is organized by teams responsible for specific patient panels. The team includes the provider's staff at minimum and the scope of responsibility for the team is limited to the scope of services the practice provides directly.
Identification number 2.1.B. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Care teams consistently leverage morning huddles, chart preparation, and other team-based activities that demonstrate effective communication designed to improve patient care.
Identification number 2.1.C. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Care teams leverage data tracked by the practice regarding labs, testing, and referrals to reduce service duplication and medical errors.

A team for every patient: level 2

Capacity information	Capacity
Identification number 2.2.A. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Core workflows are examined and roles assigned to promote top license performance for all team members.
Identification number 2.2.B. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has an active process for empaneling patients and maintaining and evaluating panels. Patient panels should be adjusted regularly to ensure patients are empaneled with teams that have the capacity and skill to address their needs; at least quarterly.

A team for every patient: level 3

Capacity information	Capacity
Identification number 2.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Care teams can address the full continuum of physical and behavioral health needs. These teams may include participants outside of the practice.

A team for every patient: level 3	
Identification number 2.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Teams use documented policies, systems, and processes to coordinate with community-based organizations to address patients' health related social needs.

Resource allocation strategy

Practice has and uses a documented strategy to prioritize resource use across all empaneled patients. The strategy includes addressing medical need, behavioral health diagnosis, and health-related social needs.

Resource allocation strategy: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 3.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has a process for identifying individuals that need greater care management.
Identification number 3.1.B. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has a process for receiving admission notifications either from hospitals, payers, or health information exchange (HIE) systems.
Identification number 3.1.C. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice follows up with patients following an inpatient stay. The follow-up visit is scheduled within one week of discharge.

Resource allocation strategy: level 2

Capacity information	Capacity
Identification number 3.2.A. **Mandatory for level 2 recognition** Yes: ☒ No: ☐ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has a process to identify patients with an ED visit that could benefit from follow-up and uses that process to prioritize patient outreach.
Identification number 3.2.B. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	When clinically indicated, practice conducts follow up visit within one week of ED visit, for patients identified through prioritization process.
Identification number 3.2.C. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice follows up with patients following an inpatient stay. The follow-up visit occurs within two weeks of discharge and can be rendered via telemedicine when clinically appropriate.

Resource allocation strategy: level 3

Capacity information	Capacity
Identification number 3.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice leverages risk stratification tool (either used by the plan with data shared with the provider or by the practice) to identify and prioritize additional care management, care coordination, and closure of gaps in care including physical health, behavioral health, and/or social risk.
Identification number 3.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has workflows that incorporate the information from the risk stratification tool into business processes and clinical workflows.

Behavioral health integration

Behavioral health integration: level 1

Practice can demonstrate it has the following competencies or has a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity

Identification number
4.1.A.
 	
Mandatory for level 1 recognition
Yes: ☒ No: ☐
 	
Attestation required for PCMH recognition
Yes: ☒ No: ☐
	Practice satisfies "Intermediate I" standards for Integrated Care in the Washington State Integrated Care Assessment for Primary Care (WA-ICA)[3] in the following domains:
	• Domain 1: Case finding, screening, referral to care
	  ○ Practice engages in systematic BH screening of targeted patient groups (e.g., those with diabetes, CAD), with follow-up for assessment
	• Domain 4: Ongoing care management
	  ○ Practice proactive follows up (no less than monthly) to ensure engagement or early response to care
	• Domain 5: Self-management support that is culturally adapted
	  ○ Practice provides brief patient education on BH condition, including materials/handouts and symptom score reviews, but limited focus on self-management goal setting
	• Domain 6: Multidisciplinary team (including patients) used to provide care
	  ○ Practice's care teams include a PCP, the patient, and ancillary staff member at a minimum
	  ○ Practice engages in regular written communication (notes/consult reports) between PCP and BH providers, occasional information exchange via ancillary staff, on complex patients

[3] WA ICA for Primary Care Settings.pdf (waportal.org)

Behavioral health integration: level 2

Capacity information	Capacity

Identification number
4.2.A.
 	
Mandatory for level 2 recognition
Yes: ☒ No: ☐
 	
Attestation required for PCMH recognition
Yes: ☒ No: ☐
	Practice satisfies "Intermediate II" standards for integrated care in the Washington State Integrated Care Assessment for Primary Care (WA-ICA) in the following domains:
	• Domain 1: Case finding, screening, referral to care
	  ○ Practice conducts systematic behavioral health (BH) screening of all patients, with follow-up for assessment and engagement
	  ○ Enhanced referral to internal/co-located BH clinician/psychiatrist, with assurance of warm handoffs when needed
	• Domain 4: Ongoing care management
	  ○ Practice uses tracking tool to monitor symptoms over time and proactive follow-up with reminders for outreach
	• Domain 5: Self-management support that is culturally adapted
	  ○ Patient education and participation in self-management goal setting (e.g., sleep hygiene, medication adherence, exercise)
	• Domain 6: Multidisciplinary team (including patients) used to provide care
	  ○ PCP, patient, ancillary staff member, care manager, BH providers
	  ○ Regular in-person, phone, or e-mail communications between PCP and BH providers to discuss complex cases

Behavioral health integration: level 3

Capacity information	Capacity

Identification number
4.3.A.
 	
Mandatory for level 3 recognition
Yes: ☒ No: ☐
 	
Attestation required for PCMH recognition
Yes: ☒ No: ☐
	Practice satisfies level 2 requirements and practice satisfies "Advanced" standards for integrated care in the Washington State Integrated Care Assessment for Primary Care (WA-ICA) in any 4 of the 8 domains shown below as determined by the practice.
	• Domain 1: Screening, referral to care and follow-up
	  ○ Analysis of patient population to stratify patients with high-risk BH conditions for proactive assessment and engagement
	  ○ Enhanced referral facilitation with feedback via electronic health records (EHR) or alternate data-sharing mechanism and accountability for engagement
	• Domain 2: Evidence-based care for preventive interventions and common behavioral health conditions
	  ○ Systemic tracking of symptom severity; protocols for intensification of treatment when appropriate
	  ○ PCP-managed, with care management supporting adherence between visits and BH prescribers/psychiatrist support
	  ○ Broad range of evidence-based psychotherapy provided by co-located BH providers as part of overall care team, with exchange of information
	• Domain 3: Information exchange among providers
	  ○ Routine sharing of information through electronic means (registry, shared EHR, shared care plans)
	• Domain 4: Ongoing care management
	  ○ Tracking integrated into EHR, including severity measurement, visits, care management interventions (e.g., relapse prevention techniques, behavioral activation), proactive follow-up; selected medical measures (e.g., blood pressure, A1C) tracked when appropriate

Behavioral health integration: level 3

- Domain 5: Self-management support that is adapted to culture, socioeconomic and life experiences of patients
    - Systematic education and self-management goal setting, with relapse prevention and care management support between visits
- Domain 6: Multidisciplinary team (including patients) to provide care
    - PCP, patient, ancillary staff member, care manager, BH providers, psychiatrist (contributing to shared care plans)
    - Weekly team-based case reviews to inform care planning and focus on patients not improving behaviorally or medically, with capability of informal interaction between PCP and BH providers
- Domain 7: Systematic quality improvement
    - Ongoing systematic quality improvement with monitoring of population-level performance metrics, and implementation of improvement projects by QI team or champion
- Domain 8: Linkages with community and social services that improve general health and mitigate environmental risk factors
    - Developing, sharing, and implementing unified care plan between agencies, with SDOH referrals tracked

Patient support

Ensure patients' goals, preferences, and needs are integrated into care and patients have access to self-management tools.

Patient support: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 5.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Has identified mechanisms for patients and caregivers to provide input and feedback on quality, satisfaction, and ways to maximize patient engagement in their own care such as patient focus groups, surveys, and other engagement tools.
Identification number 5.1.B. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has identified how to document patient feedback, review on a quarterly basis, and used to improve care.

Patient supports: level 2

Capacity information	Capacity
Identification number 5.2.A. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has established mechanisms for patients and caregivers to provide input and feedback on quality, satisfaction, and ways to maximize patient engagement in their own care such as patient focus groups, surveys, and other engagement tools.
Identification number 5.2.B. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has a documented strategy for identifying patients that would most benefit from engagement and use of patient appropriate self-management tools and can demonstrate it is used.
Identification number 5.2.C. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice documents patient feedback, reviews it no less than quarterly, and has documented processes for incorporating the feedback into the patient engagement strategy.
Identification number 5.2.D. **Mandatory for level 2 recognition** Yes: ☐ No: ☒	Teams engage in shared decision making with patients that respects their personal goals.

Patient supports: level 2

Attestation required for PCMH recognition Yes: ☐ No: ☒	

Patient supports: level 3

Capacity information	Capacity
Identification number 5.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has appropriate patient decision aids, personal digital assistants and/or self-management support tools for chronic diseases and has practice workflows to use them. Materials should be linguistically and culturally appropriate to patient population.
Identification number 5.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice actively engages populations that would benefit from self-management and provides the support necessary for patients to successfully use the self-management tools.
Identification number 5.3.C. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice implements strategies identified through the patient and family engagement process that bolster patient engagement in their own care and satisfaction with the care they receive.

Care coordination strategy

Practice coordinates care to minimize gaps in care, ensure patients are connected to referred resources, and ensure general continuity of services.

Care coordination strategy: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 6.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Provider includes a summary of relevant medical history and plan of care with referrals and maintains ongoing communication to provide and receive relevant status updates regarding the referred care.
Identification number 6.1.B. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Patients provided with individualized clinical summaries of their visit (available in languages appropriate for patient population).
Identification number 6.1.C. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Conduct medication reconciliation following patient engagement with other providers.

Care coordination strategy: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Identification number 6.1.D. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practices identifies patients with complex physical, behavioral, or social needs and offers resources (educational materials, resource access information, etc.).

Care coordination strategy: level 2

Capacity information	Capacity
Identification number 6.2.A. **Mandatory for Level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Refers to community resources (such as food banks, shelters, housing assistance).

Care coordination strategy: level 3

Capacity information	Capacity
Identification number 6.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Tracks, or has a documented plan to track within one year, referrals to community resources until the outcome of the referral is validated.
Identification number 6.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has documented care plan for patients identified through the practice's systematic approach for identifying high risk patients (this could be provided by plans or analysis conducted internally).
Identification number 6.3.C. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Implements care compacts with key specialty providers that establish responsibilities while coordinating on patient care.

Expanded access

Practice offers same day appointments for routine and urgent needs, evening and weekend hours, 24/7 clinical advice, telephonic access, and communication through IT innovations. Access is provided for both physical and behavioral health.

Expanded access: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 7.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice ensures appropriate appointment availability and no later than one week for patients seeking care following an emergency room visit or hospital admission. Visit may be provided via telemedicine if clinically appropriate.

Expanded access: level 2

Capacity information	Capacity
Identification number 7.2.A. **Mandatory for level 2 recognition** Yes: ☒ No: ☐ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice offers same day appointments for urgent needs.

Expanded access: level 3

Capacity information	Capacity
Identification number 7.3.A. **Mandatory for level 3 recognition** Yes: ☒ No: ☐ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice offers evening and weekend hours.
Identification number 7.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has expanded access capabilities fully in place for both physical and behavioral health
Identification number 7.3.C. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has processes in place to collect feedback from patients and families regarding access needs and uses these processes to improve/inform expanded access strategies

Culturally attuned care

Practice provides culturally supportive care in location, language, and demographic composition.

Culturally attuned care: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 8.1.A.	Practice has real-time interpretation services for top 3 languages common among the patient population.
Mandatory for level 1 recognition Yes: ☐ No: ☒	
Attestation required for PCMH recognition Yes: ☐ No: ☒	

Culturally attuned care: level 2

Capacity information	Capacity
Identification number 8.2.A. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice quality improvement strategies related to patient engagement include consideration for demographics.
Identification number 8.2.B. **Mandatory for level 2 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice regularly offers at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, and/or alternate location visits.

Culturally attuned care: level 3

Capacity information	Capacity
Identification number 8.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has a documented strategy to support having provider team compositions that reflect patient panel composition as informed by race and ethnicity data.
Identification number 8.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practices trains staff on culturally appropriate care.
Identification number 8.3.C. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practices partner with local culturally attuned community-based organization to better understand and participate in addressing the community's health-related needs.

Health literacy

Patient-facing forms and information are accessible for a diverse population (language, reading level, etc.).

Health literacy: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 9.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	When using practice-developed materials, practice utilizes patient-facing forms and information that are written at the appropriate level and are available in languages that reflect the patient population.

Health literacy: level 2

Capacity information	Capacity
Identification number 9.2.B. **Mandatory for level 2 recognition** Yes: ☒ No: ☐ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice's patient-facing forms adhere to all standards and are available in several accessible formats. Standards include the following: • Are readable at a 5th grade reading level • Are available in languages that reflect the patient population • Use inclusive, non-stigmatizing language • Reaffirm the confidentiality of information • Adhere to ADA accessibility guidelines

Health literacy: level 3

Capacity information	Capacity
Identification number 9.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice's patient-facing forms adhere to all standards and are available in the accessible formats needed by the population. Standards include the following: • Are readable at a 5th grade reading level • Are available in languages that reflect the patient population • Use inclusive, non-stigmatizing language • Reaffirm the confidentiality of information • Adhere to ADA accessibility guidelines
Identification number 9.3.C. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has an explicit approach to accommodating patients with low vision and/or hearing.

Data informed performance management

Practice builds capacity to query and use data to support clinical processes, population health, and business decisions that result in improved quality and financial performance.

Data informed performance management: level 1

Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.

Capacity information	Capacity
Identification number 10.1.A. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has ability to send and receive data regarding attribution, care coordination, and quality performance to and from plans electronically (not paper or fax).
Identification number 10.1.B. **Mandatory for level 1 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice has staff that can review, understand, and disseminate performance related information provided by plans or generated internally. Staff serve as designated point of contact for communicating with plans regarding data and performance.

Data informed performance management: level 2

Capacity information	Capacity
Identification number: 10.2.A. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Incorporates results of performance data into team workflows (e.g., improving gap closure for measures with poorer performance).
Identification number 10.2.B. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Process for quality improvement using data according to an identified process improvement model.
Identification number 10.2.C. **Mandatory for level 2 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Ensure accurate and up-to-date provider data (performance, attribution, or other data to support contract and PCTM requirements) to payers for overall network monitoring.
Identification number 10.2.D. **Mandatory for level 2 recognition** Yes: ☐ No: ☒	Practice has a documented plan to systematically measure and track both physical and behavioral patient outcomes as specified for the model.

Data informed performance management: level 2

Attestation required for PCMH recognition Yes: ☐ No: ☒	

Data informed performance management: level 3

Capacity information	Capacity
Identification number 10.3.A. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Receives and has process for following up on admission, discharge, and transfer data as needed to support the care coordination accountability.
Identification number 10.3.B. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practices contribute data to state clinical data repositories.
Identification number 10.3.C. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice systematically measures and tracks both physical and behavioral patient outcomes as specified for the model.
Identification number 10.3.D. **Mandatory for level 3 recognition** Yes: ☐ No: ☒	Use available resources including payer claims and administrative data (or other relevant data based on the payment model the provider participates in) to drive quality improvement processes and sustain outcomes.

Data informed performance management: level 3

Attestation required for PCMH recognition Yes: ☐ No: ☒	
Identification number 10.3.E. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Apply data-driven quality improvement processes for all patients and all providers (e.g., not limited to identifying gaps in care and closing them one patient at a time; engages in trend analysis for total population).
Identification number 10.3.F. **Mandatory for level 3 recognition** Yes: ☐ No: ☒ **Attestation required for PCMH recognition** Yes: ☐ No: ☒	Practice can stratify analysis by different demographics and appropriate patient characteristics to support efforts to improve health equity.