Washington Multi-payer Primary Care Transformation Initiative
PCTI Provider 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 collaborated to develop the WA Primary Care Transformation Initiative (PCTI) 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 provider recognition process, and a quality framework to support improved equity and health outcomes;
- Implementing aligned payment models providing flexibility and incentives for providers to succeed;
- Offering practice supports that ensure practices have the resources needed to grow their capability to provide comprehensive primary care; and,
- Aligning purchaser and payer policy to drive the system forward in a focused direction.

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

Additionally, the federal Center for Medicare and Medicaid Services (CMS) has selected Washington to participate in its new Making Care Primary (MCP) model. MCP is a complimentary effort to WA's PCTI, expanding the multi-payer approach by bringing Medicare to the table. MCP and PCTI share many similar components and a common set of goals. HCA and its partners are working to maximize alignment and the promising impact of the two models.

Primary Care Transformation Initiative Provider Recognition Accountabilities

A critical component of the Primary Care Transformation Initiative (PCTI) is the centralized recognition process, the Primary Care Practice Recognition (PCPR) program. This process will evaluate providers' capabilities across a range of accountabilities. Based on this evaluation, providers will be assigned a Recognition Level rating from 1 to 3. This process has several intended outcomes, some which will be realized earlier in Washington's transformation journey and others further along. Implementation of the recognition process is anticipated to begin end of summer 2024.

Initial outcomes:

- Provide transparency into the capabilities of individual primary care providers and the broader primary care system
- Help payers decide how to prioritize the practice supports they will provide to participating providers under the model.

Intended future outcomes:

- Establish eligibility for participation in different payment models (transformation funding, quality payments, comprehensive care payments) through a single process recognized across participating payers
- Provide a mechanism for providers to request transformation funding and other available supports

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

Provider 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 provider must meet all required elements across all accountabilities for a given recognition level. Additionally, they must 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. Refer to the scoring tool for additional information.

Practices recognized as a National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH) or participating in the Centers for Medicare & Medicaid Services (CMS) Making Care Primary (MCP) model can receive a recognition level equivalent to their NCQA PCMH level or MCP track by submitting an abbreviated workbook. While PCPR, NCQA PCMH, and MCP have many similarities, they are not identical.

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-recognized:** 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 recommended immunizations, patient education, behavioral health screening, and self-management support

WHOLE-PERSON CARE - LEVEL 2	
Capacity Information	**Capacity**
Identification Number: 1.2.A. **Mandatory for Level 2 recognition:** Yes: ☒ No: ☐ **Attestation required for PCMH-recognized:** 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.

[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	
Identification Number: 1.2.B. **Mandatory for Level 2 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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 1: Practice can demonstrate they have the following competencies or have a robust strategy for implementing the accountability in the next year.	

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-recognized:** 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-recognized:** 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: ☒	Care teams are capable of addressing 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	
Attestation required for PCMH-recognized: Yes: ☐ No: ☒	
Identification Number: 2.3.B. **Mandatory for Level 3 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** 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-recognized:** Yes: ☐ No: ☒	Practice has a process for receiving admission notifications either from hospitals, payers, or HIE systems.
Identification Number: 3.1.C. **Mandatory for Level 1 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:
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 provider(s), 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-recognized:
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 BH screening of all patients, with follow-up for assessment and engagement
	  ○ Enhanced referral to internal/co-located BH clinician(s)/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 provider(s)
	  ○ Regular in-person, phone, or e-mail communications between PCP and BH provider(s) 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-recognized:
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 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 prescriber(s)/psychiatrist support
	  ○ Broad range of evidence-based psychotherapy provided by co-located BH provider(s) 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
	• 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 provider(s), 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 provider(s) • Domain 7: Systematic Quality Improvement ○ Ongoing systematic quality improvement with monitoring of population-level performance metrics, and implementation of improvement projects by QI team/champion • Domain 8: Linkages with community/social services that improve general health and mitigate environmental risk factors Developing, sharing, 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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: ☒ **Attestation required for PCMH-recognized:** Yes: ☐ No: ☒	Teams engage in shared decision making with patients that respects their personal goals.

PATIENT SUPPORTS – LEVEL 3	
Capacity Information	**Capacity**
Identification Number: 5.3.A. **Mandatory for Level 3 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** Yes: ☐ No: ☒	Practice offers evening/weekend hours.
Identification Number: 7.3.B. **Mandatory for Level 3 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** 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. **Mandatory for Level 1 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** Yes: ☐ No: ☒	Practice has real-time interpretation services for top 3 languages common among the patient population.

CULTURALLY ATTUNED CARE – LEVEL 2	
Capacity Information	**Capacity**
Identification Number: 8.2.A. **Mandatory for Level 2 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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-recognized:** 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: ☒ **Attestation required for PCMH-recognized:** 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 3	
Capacity Information	**Capacity**
Identification Number: 10.3.A. **Mandatory for Level 3 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** Yes: ☐ No: ☒	Receives and has process for following up on Admit/Discharge/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-recognized:** 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-recognized:** 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: ☒ **Attestation required for PCMH-recognized:** 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.
Identification Number: 10.3.E. **Mandatory for Level 3 recognition:** Yes: ☐ No: ☒ **Attestation required for PCMH-recognized:** 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-recognized:** Yes: ☐ No: ☒	Practice can stratify analysis by different demographics and appropriate patient characteristics to support efforts to improve health equity.