TABLE 2 PCPCH Health Equity Designation Measures

#	PCPCH Measures for the Health Equity Designation
1	1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
2	1.C.1 PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.
3	1.E.2 PCPCH provides patients with access to an electronic copy of their health information in an accessible format.
4	1.G. PCPCH offers telehealth services to its patients in their primary language.
5	1.G.2. PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.
6	1.G.3 PCPCH regularly provides patient care in community-based settings.
7	2.A.3 PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.
8	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 educational improvement activities.
9	2.E.3 PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families or caregivers for follow-up care.
10	3.D.2 PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.
11	3.D.3 PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.
12	3.E.3 PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach strategy.
13	4.C.2 PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.
14	5.A.3 PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category.
15	5.B.3 PCPCH assists its patients in navigating the cost and payment options for their care.
16	6.A.1 PCPCH provides written patient materials in languages other than English.
17	6.A.2 PCPCH assures that patient communications and materials are at an appropriate health literacy level.
18	6.B.2 PCPCH provides culturally and linguistically appropriate patient-specific education resources and offers or connects patients, families, and caregivers with self-management support resources.
19	6.C.2 PCPCH surveys a sample of its population on their experiences with specific areas of care, including health equity, and demonstrates the utilization of survey data in quality improvement activities.
20	6.E.3 PCPCH partners with one or more traditional health workers or traditional health worker services.