COLORADO
Department of Health Care Policy & Financing

ACC APM Program Year 2021 - Structural Measure Specifications

Possible Points	MEASURE NAME	MEASURE DESCRIPTION	DOCUMENTATION REQUIREMENTS	SIM	CPC+	NCQA PCMH
		IMPLEMENT CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES				
10	**Quality Improvement**	The practice identifies, sets goals, analyzes data and acts to improve performance on at least one performance measure.	o Project plan that includes: o Identified goals; o Analysis of related data; AND o Actions to improve performance on at least one identified performance measure	X		X
20	**Improvement Activities**	The practice identifies, sets goals, analyzes data and acts to improve performance on three or more performance measures, including at least one behavioral health measure.	o Project plan for each identified measure that includes: o Identified goals; o Analysis of related data; AND o Actions to improve performance on identified measures			X
30	**QI Strategy & QI Plan**	The practice develops a QI Strategy & Agency QI Plan. This includes a QI Team and regularly scheduled QI meetings. The QI team should include representation from all areas of the practice.	o QI Meeting schedule; AND o Documented Quality Improvement Strategy; AND o Documented Quality Improvement Plan	X		
40	**Use Data Effectively**	The practice demonstrates that it collects clinical quality performance data on at least three performance measures and assesses the results to inform strategies to improve population health management. This should be done at least quarterly on the practice-level and provider-level.	o One example of a clinical quality performance data report for each performance measure; AND o Copy of meeting minutes where reports are reviewed and assessed on the practice-level and provider-level; AND o Documented actions taken from data review	X	X	X
50	**Patient Satisfaction**	The practice involves patients/families in quality improvement activities or on the patient-family advisory council (PFAC), with a specific focus on improving patient satisfaction when patients/families are in attendance and can provide feedback.	o Written process for involving patients/families on the QI Team or PFAC; AND o Copy of QI Team or PFAC minutes that includes the patients/families in attendance; AND o Process for reviewing patient recommendations for possible implementation into the clinic setting	X	X	X

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		TEAM BASED CARE				
10	**Empanelment**	The practice assists patients/families to select a provider and/or care team and documents the selection in practice records. The practice reviews and validates provider empanelment regularly.	o Documented process for identifying patient's choice of provider and/or care team in the chart; AND o Documented process for reviewing and validating provider empanelment	X	X	X
20	**Define Team**	The practice identifies clinical and non-clinical team members (including front desk staff, referral coordinator, patient navigator, etc.) and defines roles and responsibilities for each.	o Written job descriptions, including title, qualifications, and defined roles, for each team member	X		X
30	**Team Training**	The practice develops a team-based strategy and provides on-going training of team members to: o Coordinate care for individual patients; OR o Support patients/families in self-management; OR o Manage the patient population	o Documented description & schedule of training for team members; AND o Documented strategy for team-based training			X
40	**Team Meetings**	The practice holds scheduled meetings to address practice functioning, and conducts patient care team meetings (such as huddles).	o Documented description of team meetings, including frequency and who attends each meeting; AND o At least one dated example of agenda, minutes, or staff memos about the team meeting	X		X
50	**Interdisciplinary Team**	The practice utilizes interdisciplinary team members such as Social Workers, Case Workers, Community Health Workers, and Promotores(as) to assist patients in managing their care.	o Written job descriptions, including title, qualifications, and defined roles, for each team member, including interdisciplinary team members; AND o At least one example of interdisciplinary team's involvement in patient's care	X		

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		ACCESS				
10	**Availability of Appointments**	The practice has standards for appointment availability, including providing same-day appointments. Availability standards may be established and measured for a variety of appointment types (such as urgent care, new patient physicals, follow-up appointments) or the practice may set a single standard across all visit types.	o Third next available appointment report with at least five days of data; AND o Documented process explaining availability standards, including same-day appointment policy. Documented process should define appointment types and amount of time for each appointment type			X
20	**Follow-up for Missed Appointments**	The practice has a process for following-up with patients who have missed appointments.	o Documented process for phone or email follow-up on missed appointments, including documentation in a patient chart; AND o At least one de-identified example of documentation in a patient chart			X
30	**Improving Patient/Family Access**	The practice identifies opportunities to improve patient/family access and act on at least one identified opportunity (such as patient access issues identified in the following measures: Availability of Appointments and Follow-Up for Missed Appointments). The practice should: o Describe criteria for selecting their patient/family access areas of focus; o Describe how the practice monitors these areas of focus; o Detail the target to improve these areas of focus; o Outline process for reviewing the criteria for selecting the areas of focus; o Outline when targets may be adjusted	o Project plan including the criteria, monitoring process, improvement target, process for reviewing criteria, and target adjustment plan; AND o A written description of the actions taken to improve patient/family access for one identified opportunity			X

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40	**Alternative Encounters**	The practice provides alternative types of clinical encounters, such as: o Telephone/video chat o Secure instant messaging o Group visits o Shared medical appointments o Home visits	o Documented process for arranging appointments for alternative encounters, including frequency of availability and type of encounter; AND o Report or screenshot of appointment schedule showing availability of alternative encounters.		X	X
50	**Accepting New Patients**	The Practice accepts new Medicaid clients for the majority of the year (seven out of 12 months)	o Written Agreement with the RAE; OR o Monthly Provider Directory showing the practice was "open" for at least seven of the previous 12 months			

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		CARE MANAGEMENT				
10	**Standing Orders**	The practices uses written standing orders for services.	o At least one example of a written, signed standing order used by the practice	X		X
20	**Screening and Follow-Up**	The practice uses standardized/validated screening tools (for example: SBIRT, PHQ-9, Ages and Stages Questionnaire), and develops a follow-up process for at least three conditions, including one behavioral health condition.	o Blank screening tool for each identified condition (at least three); AND o Documented process for managing follow-up care	X	X	X
30	**Gaps in Care**	The practice identifies a strategy to identify gaps in care, and implements proactive care management to avoid potential overlaps or gaps in services and care for preventive services, immunizations, chronic or acute services, or patients not recently seen by the practice. The practice uses data regularly to proactively identify populations of patients and remind them or their families, of needed care based on patient information, clinical data, health assessments, and evidence-based guidelines.	o Strategy and documented process to identify gaps in care; AND o Documented process for proactively reaching out to identified patients/families	X		X
40	**ED & Hospital Follow-Up**	The practice proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department (ED) visit. The practice contacts patients to evaluate their status after an ED or hospital visit and schedules follow-up appointments to reduce unnecessary ED utilization and ensure effective transitions of care.	o Documented process for emergency department and hospital follow-up, including timeframe for follow-up; AND o Documented process for identifying which ED/hospital visits the practice has determined require follow-up	X	X	X
50	**Risk Stratification**	The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need.	o Documented risk stratification methodology; AND o Documented process used to identify and provide care management for patients, based on risk stratification	X	X	X

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		CARE COORDINATION				
10	**Clinical Question & Data Sharing**	The practice gives consultants or specialists the succinct reason for referral, which may be stated as the "clinical question" (i.e. the general purpose of the referral). The practice includes follow-up communication or information in the referral.	o A documented process that includes communication requirements when referrals are requested, specifically: o The type of referral (consultation or single patient visit); o Request for shared-or co-management of the patient for a specific condition for an indefinite or limited time; o Temporary or long-term principal care, such as a transfer; AND o At least one de-identified example of a completed referral request			X
20	**Care Compacts**	The practice maintains formal and informal agreements with a subset of specialists based on established criteria (including at least one Behavioral Health provider). Agreements typically indicate the type of information that will be provided when referring a patient to a specialist, and expectations regarding timeliness and content of response from the specialist. Include key contact for each provider's office.	o At least one example of a care compact with a specialist; AND o At least one example of a care compact with a Behavioral Health provider	X	X	X
30	**Referral Tracking**	Practice tracks referrals until the consultant's or specialist's report is available. This includes flagging and following up on overdue reports.	o Documented process for tracking referrals; AND o Referral tracking log		X	X

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40	**Lab & Imaging Tracking**	o The practice tracks lab and imaging tests from the time they are ordered until results are available, and flags test results that have not been made available. o The practice flags abnormal results of lab or imaging tests brings these to the attention of the clinician, to ensure timely follow-up with the patient/family/caregiver. o The practice provides timely notification to patients about test results (normal and abnormal). Please note that filing the report in the medical record for discussion during a scheduled office visit does not meet this requirement.	o Documented process for tracking lab/imaging results; AND o Evidence of implementation			X
60	**BH Integration**	The practice integrates with behavioral health. This could be through Care Management Agreements, partial integration (co-location with some systems shared), or full integration (co-location with all systems shared).	o Documentation of Behavioral Health Integration through co-location; OR o Documentation of Care Management Approach (CPC+ Definition, see https://innovation.cms.gov/Files/x/cpcplus-bhinteg-options.pdf)	X	X	X

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		PROVIDING SELF-MANAGEMENT SUPPORT				
10	**Shared Decision Making Tools**	The practice identifies a Shared Decision Making Tool for at least one condition.	o Blank copy of identified tool(s)			X
20	**Assess Self-Management Support Capability**	The practice assesses practice capability and plans for support of patient's self-management.	o Documented process for assessment and evaluation of practice's capability to support self-management; AND o Documented plan based on evaluation of assessment for support of self-management		X	
30	**Self-Management Tools**	The practice identifies Self-Management tools, including tools to address potential barriers to meeting goals, to support patients in managing their physical and/or mental health outside of the doctor's visit. The practice implements a tool for at least one identified condition.	o One de-identified copy of each identified tool			X
40	**Implement Self-Management Support**	Whole-person care/self-management support includes the provision of comprehensive care and self-management support, while emphasizing the spectrum of care needs. The practice needs to implement self-management support for at least 3 conditions (including at least one behavioral health condition), including patient-specific educational and community resources.	o Documented process for self-management support for each condition; AND o De-identified example of at least one self-management support plan for each condition		X	X
50	**Individual Care Plan**	The care team and patient/family collaborate (at relevant visits) to develop and update an individual care plan that includes: o Patient preferences o Patient diagnosis o Functional/lifestyle goals o Treatment goals o Potential barriers to meet goals o Patient instructions/education o A self-management plan, as appropriate (developed with patient input) The individual care plan is to be provided in writing to the patient/family, and it supports patient-centered care.	o Three documented de-identified individual care plans showing all elements listed in the description for this measure.	X	X	X

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		OTHER				
40	**Potentially Avoidable Costs/ Complications**	Utilizing the Prometheus dashoboard tool provided by HCPF, Identify key focus areas for lowering Potentially Avoidable Costs(PACs). Then develop and implement an action plan to lower your PAC rate over the next year.	Completed action Plan			