COLORADO
Department of Health Care Policy & Financing

ACC APM 1 - Structural Measure Specifications
Program Year 2023

All structural measures are valued at 20 points.
Primary care medical providers (PCMPs) can earn no more than 100 points on structural measures.
PCMPs that earn Patient-Centered Medical Home recognition credit and Federally Qualifed Health Centers are not permitted to report on any structural measures.
See the APM 1 Guidebook on the APM 1 website for more information: https://hcpf.colorado.gov/alternative-payment-model-1-apm-1

Focus Area	Measure Name	Measure Description	Documentation Requirements
Access	**Alternative Encounters**	The practice provides alternative types of clinical encounters, such as: • Telephone/video chat • Secure instant messaging • Group visits • Shared medical appointments • Home visits	• Documented process for arranging appointments for alternative encounters, including frequency of availability and type of encounter; AND • Report or screenshot of appointment schedule showing availability of alternative encounters.
Access	**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.	• Third next available appointment report with at least five days of data; AND • Documented process explaining availability standards, including same-day appointment policy. Documented process should define appointment types and amount of time for each appointment type.
Care Coordination	**Behavioral Health 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).	• Documentation of Behavioral Health Integration through co-location; OR • Documentation of Care Management Approach (CPC+ Definition, see https://innovation.cms.gov/Files/x/cpcplus-bhinteg-options.pdf).
Care Management	**Emergency Department & 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.	• Documented process for emergency department and hospital follow-up, including timeframe for follow-up; AND • Documented process for identifying which ED/hospital visits the practice has determined require follow-up.
Access	**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: • Describe criteria for selecting their patient/family access areas of focus; • Describe how the practice monitors these areas of focus; • Detail the target to improve these areas of focus; • Outline process for reviewing the criteria for selecting the areas of focus; • Outline when targets may be adjusted	• Project plan including the criteria, monitoring process, improvement target, process for reviewing criteria, and target adjustment plan; AND • A written description of the actions taken to improve patient/family access for one identified opportunity.

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Providing Self-Management Support	**Individual Care Plan**	The care team and patient/family collaborate (at relevant visits) to develop and update an individual care plan that includes: • Patient preferences • Patient diagnosis • Functional/lifestyle goals • Treatment goals • Potential barriers to meet goals • Patient instructions/education • 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.	• Three documented de-identified individual care plans showing all elements listed in the description for this measure.
Team Based Care	**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.	• Written job descriptions, including title, qualifications, and defined roles, for each team member, including interdisciplinary team members; AND • At least one example of interdisciplinary team's involvement in patient's care.
Implement Continuous Quality Improvement Activities	**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.	• Written process for involving patients/families on the QI Team or PFAC; AND • Copy of QI Team or PFAC minutes that includes the patients/families in attendance; AND • Process for reviewing patient recommendations for possible implementation into the clinic setting.
Care Coordination	**Referral Tracking**	Practice tracks referrals until the consultant's or specialist's report is available. This includes flagging and following up on overdue reports.	• Documented process for tracking referrals; AND • Referral tracking log.