NYS Advanced Primary Care (APC) Milestone Technical Specifications

PARTICIPATION MILESTONE	*Capability: Practice demonstrate readiness through either initial gating assessment or through certification*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support, to qualify for SIM-funded practice transformation	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to APC Participation Agreement at Gate 1	Practice completes the Self-Assessment Tool; practices and TA's complete the APC Practice Attestation form	Documents should be signed by both clinical and business leaders				
Commitment to Designate Change Agents/Practice Leaders at Gate 1	Designated Clinical Practice Leader Designated Business Practice Leader Commitments to expectations, governance, meeting attendance and leadership related to APC and name of practice leaders completing orientation Create/define staff roles and assignment to integrate criteria	Provide contact information of designated practice leaders; Practice proactively commits to engaging in TA services Ensure that roles and task definitions support activities				

	for TA services both on-site, remotely and establish proactive engages with all parties	needed to progress towards Milestones development				
Commitment to Participate in TA Vendor Gate 1 Orientation	Practice participation in TA vendor Orientation	Attendance sheet completed by TA entity verifying participation				
Commitment to work to achieve Gate 2 Milestones in one year			Practices that start at Gate 2 will complete the Self-Assessment Tool; practices and TA's complete the APC Practice Attestation form	Documents should be signed by both clinical and business leaders		
Commitment to Participation in TA Entity activities and Learning (if electing support) at Gate 2			Attendance by one practice lead or designee as appropriate to each covered topic as required; Engagement in learning activities that include sharing practice and APC-wide learning opportunities	Provide Attendance records Verification of engagement by TA entity		

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PATIENT-CENTERED CARE MILESTONE	*Capability: Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to Patient Engagement activities Integrated into Workflows within one year, (by Gate 2)			Plan for either a patient satisfaction survey, focus group or Patient-Family Advisory Council (PFAC) that includes representative practice populations	Provide copy of selected patient satisfaction survey or materials to begin focus group or PFAC, which should include design of a charter, patient selection process, staff orientation etc.		
Implementation of patient engagement integrated into workflows including Quality Improvement (QI) Plan (grounded in evidence-based criteria) by Gate 3					Implement and provide evidence of at least one (annual) patient engagement strategy that results in use of at least one QI project that will effect practice change Demonstrate process for incorporating care team staff, patient and families, and/or community-based entities into strategy efforts (e.g.	Complete a patient survey for at least 8% of discrete patients in practice at two 6-month intervals; Make results available to patients; Provide a survey sample and provide a report of results; Show area of Quality

					establishing a QI effort such as addressing "wait times" or patient reported outcomes)	Improvement (QI) selection and results; if focus group or PFAC (quarterly), include sample Agendas, meeting minutes and QI strategies and results
Commitment to creating a process for Advanced Directive Discussion with Patients at Gate 1 Commitment to Advanced Directives Discussion with all Patients >65 at Gate 2 Commitment to sharing Advanced Directives across Medical Neighborhood, where feasible at Gate 3	Practice can demonstrate development of a process to use and report Advanced Directives (AD) Process for Advanced Directives Discussions with all >65 year old adult patients and those with advanced illness	Develop protocols/process for using Advanced Directives (AD) templates for appropriate patients (e.g. >over 65 yrs.) and those with advanced illness Template should include the minimum of: Health Care Proxy, Living Will, DNR order Provide narrative description of process and flagging reminders in chart or EHR template	Practice uses protocols/processes with goal of reporting Advanced Directives (AD) on all patients >65 years	Provide narrative description of how the practice uses protocols/processes to engage and record AD for eligible patients Provide a 3-month spreadsheet or EHR-generated report that shows numerator: (number of patients having AD in chart) and denominator: (all eligible patients seen in one year); Report should also include all declined responses (to count in both numerator and nominator) and mechanism for flagging reminders in paper chart or EHR template	Advanced Directives (to include eMOLST) are made available in electronic form to share with other health care providers and exchanged through HIE	Demonstrate that Advanced Directives are made available in electronic format for other health care providers and exchanged through HIE, and show de-identified examples of communication, where feasible

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POPULATION HEALTH MILESTONE	*Capability: Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to Participating in Prevention Agenda Activities at Gate 3					Participate in local county health collaborative Prevention Agenda calls, meetings and participate in at least two activities with Prevention agenda partners on shared priority efforts	Communicate with county health department to discuss shared goals/priorities; engage in at least two mutual Prevention Agenda activity per year and report on one (e.g. Integrating pre-conception care, efforts to promote mental emotional behavioral well-being)
Commitment to Identification and outreach to patients due for Preventive and Chronic Care Management in Gate 3					Document clinical decision support interventions that have been enabled, staff workflows and process for identifying patients due for preventive and chronic care visits (e.g. preventive screenings) and use of clinical guidelines for chronic care	Provide evidence of how preventive measures (screening) are being tracked by practice

					conditions; indicate method(s) of follow-up used	
Commitment to creating a process to refer to Structured Health Education Programs and Community Based Resources at Gate 3					Ensure that referrals made to community-based entities and resources will be managed the same as all other clinical referrals and follow-up care In conjunction with TA entities, the State will provide practices information on structured health education programs and other resources including local health departments, local office on aging, PPS community resource compendium, PHIP, and other community resources	Practices provides evidence of how they refer and track referrals to community-based entities and resources for patients with chronic conditions, or with social or behavioral health needs (e.g. screenshots of logs or EHR showing tracking of referrals)

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CARE MANAGEMENT /CARE COORDINATION MILESTONE	*Capability: Manage and coordinate care across multiple providers and settings by actively tracking the highest need patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and track and optimize transitions of care. Care Management is defined as: focus on the comprehensive support of the highest risk subset of practice's patient population. Care Coordination is defined as: the practice contributes to seamless care of all patient transitions across all environments.*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to Identify Highest Risk Patients for Care Management at Gate 2 Commitment to Integrate High Risk Patient data from other sources (including payers) at Gate 3			Practice assigns patient to specific provider care team, small practices can serve as their own care team Implement a Risk Stratification System for Care Management using a standardized tool (such as AAFP, AHRQ) or own developed process to define and track high risk patients Annotate Risk Scores for easy staff/provider access and identify care management intervention on no less than 1% of highest risk patients in entire panel	Active patients are assigned to a provider (active patients defined as last seen within 2 years) Generate consecutive 6 month report with denominator as all active patients, numerator as all empaneled patients Name and describe Risk Stratification tool; generate a consecutive 6-month report or devise spreadsheet identifying high risk patients by risk score	Practice has a system in place to actively manage high risk patients; integrate high risk patients data from other sources (including payers) Practice manages high risk patients internally or by using a collaborative "pod" model	Provide evidence of actively managing high risk patients (e.g. either through EHR or spreadsheet for patient panel or improved risk scores)
Commitment to Planning for Care Management and/or Care Coordination			Implements recruitment strategies and/or appropriate training for existing staff on Care/Case	Create job description(s) for CM/CC roles that outline practice capacities and		

(CM/CC) delivery within one year at Gate 2			Management care delivery in a practice setting Care Management Program to include the following: CM/CC needs are accomplished for no less than 2% of total empaneled population regardless of risk scores and/or highest need patients	define FTE needs based upon high risk patient population Describe provision of internal and external training (State-provided care management guidance currently being developed by the workforce workgroup) Describe staff training for coordination of care management activities in daily practice and show proof of implementation of TCM/CCM claims codes being used by practice		
Commitment to Delivering Care Management to Highest Risk Patients at Gate 3					Practice ensures that all high risk patients are offered care management by the practice, contracted entity or other identified specialty practice Demonstrate CM/CC integrated delivery through introduction of services (potentially	Provide 3 consecutive months of de-identified Case Management logs or EHR reports (as indicated in Gate 2, e.g. proof of continued care and use of TCM/CCM claims) Indicate Risk Score status

					acquired through "pods") such as nutritional care, pharmacy, behavioral health specialties Conduct structured huddles/meetings to discuss CM cases with Care Team Provide structured outreach/protocols to care transitions settings including back to home Engage/train for use of payer utilization reports of high risk patients	changes and shared integrated care delivered, follow-up appointments Provide narrative description of use of payer utilization reports to identify/ compare high risk patients as defined by the practice; Demonstrate ability to stratify data according to diversity (e.g. race, ethnicity, high risk etc.)
Behavioral Health: Commitment at Gate 1 to using Self-Assessments for BH integration and commitment to achieving Gate 2 BH Milestones within one year Commitment to integrating an Evidenced- Based process for screening,	Practice self-assessment for behavioral health integration Commitment and goal planning to reach Gate 2	Completed self-assessment for Gate 2 Milestone achievement	Use PHQ2/PHQ9 for screening of depression and use of a validated screening tool for substance and alcohol abuse Engage/participate in training for behavioral health integration in primary care settings that broadens team-based care and clinical treatment of depression	Demonstrate appropriate screening of eligible adults >age 18 Completion of staff training modality through online or in-person training of behavioral health integration Create/implement a Collaborative Care Agreement that	Use behavioral health care management services (using shared care management resources, including health home care managers) Capability of sharing the Care Plan with other health care providers in electronic form and	Describe connection to behavioral health case management services Demonstrate use of shared electronic care plan and provide screenshots of process Demonstrate linkage with social service agencies and produce a

treatment where appropriate, and referral at Gate 2 Commitment to delivering Coordinated Care Management for Behavioral Health at Gate 3			Collaborative Care Agreement with BH provider which has required elements of communication and description of process on how patients are seen, treated and tracked Define process of adherence to Behavioral Health quality Measures (Common Score Card)	defines tracking and follow-up	track patient progress Care team demonstrates integrated delivery through linkage with regional social services agencies, such as support groups Demonstrate follow-up after depression and substance and alcohol abuse screening at regular intervals and referral tracking	report detailing previous 3 months of interactions Generate a 3-month follow-up report detailing appropriateness and timeliness of follow-up for applicable patients
Commitment to having a Process in place for Care Plan development at Gate 2 Commitment to Care Plan development in concert with Patient Preferences and Goals at Gate 3			Identify key components of a structured Care Plan that best fits patient needs with goals and preferences Develop plan, and create workflows that include specific goals for patient engagement Implement at least 3 nationally-recognized (e.g. AHRQ) or TA entity approved Shared Decision Making Tools (SDMA)	Guided by TA entity, review 'best practice' Care Plans and demonstrate staffing workflows needed to integrate into practice by creating a workflow chart or protocol Provide description of Care Plan process and define how patient goals and preferences are shared	Patients have a Care Plan, noting patient goals and preferences for management of chronic disease in patient record Capability of sharing the care plan with other health care providers in electronic form	Proof of patients with completed Care Plans in EHR (Numerator: patients with Care Plans, Denominator: all empaneled patients) Demonstrate improvement of percentage of patients with a care plan and include evidence of shared care planning with other providers

			tools with priority given, to quality measures included in the Common Measure Set: (e.g. colonoscopy, antibiotic use, back pain management, management of weight, depression, PSA) Integrate use of technology for record tracking and secure communication methodology (e.g. portal) and educate patient in use of secure communication Establish structured Care Plans include use of a template, tracking tool, and criteria used to identify patient needs during Care Management periods	Practice submits with the assistance of the TA entity, the use of 3 Shared Decision Making Tools (SDM) Provide a baseline EHR report or tracking tool showing percentage of people in high risk category with a care plan		
Commitment to creating (at Gate 1) and systematically utilizing a Referral Tracking System (at Gate 2)			Develop capability for systematically tracking patients throughout referral processes Create clinical/non-clinical staffing workflow patterns to track referrals made, patients seen, consultation reports	Practice provides plan for tracking patients throughout the referral process and submits example of workflow pattern Demonstrate that staff workflow assignments have	Provide operational process for systematically tracking patients throughout referral processes including BH and substance abuse Implement clinical/non-clinical	Provide 3-month de-identified EHR report or evidence of a referral tracking template used or other proof of operational process

			received and flagging of missing information	been operationalized and provide screenshots of EHR referral tracking workflow	workflow patterns to track referral sent, patient seen, and consultation report received with flagging of missing information	
Commitment to establishing Care Compacts or Collaborative Agreements for Timely Consultation with Medical Specialists and Institutions at Gate 3					Establish written Care Compacts with at least 2 high volume specialists inside or outside of practice ownership entity or demonstrate structured process for coordinated care of patients Care Compacts or description of structured process should include primary/ specialty care expectations, access to care, collaborative care management, patient communication needs, and provision of patient transition records	Describe communications, arrangements, and copy of Care Compacts or narrative process that includes expectations of both parties creating 'closed loop' in patient care Measure referrals completed (numerator) over referrals made (denominator) and demonstrate improvement in a 3 month period
Commitment to creating a Post Discharge Follow-up Process for timely transitions in care at Gate 3					Practice develops a process to receive timely notifications (e.g. ED, hospitals) Review discharge summaries for	Document a process to receive notifications Demonstrate review and reconciliation of

					missing information (e.g. pursue gaps in discharge communications) and review and reconcile medications Contact discharged patients within 72 hours; schedule and document follow-up within 7 days or as applicable Identify patients that will need internal CM/CC or that will require coordination of care from other health or community-based services	medications of 50% of discharged patients for 3 month period Demonstrate tracking of patient discharges within 72 hours, and discharges requiring patient contact: report improvement over a 3 month period all known discharges (denominator) and all patients where follow-up was made Provide examples of 2 de-identified patients with TCM/CCM showing coding utilization during 6-month period

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ACCESS TO CARE MILESTONE	*Capability: Promote access as defined by affordability, availability, navigability, accessibility, of care across all patient populations*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to providing 24/7 Access to a Provider at Gate 1 and to improve communication capabilities at Gate 2	Practice has On-call schedule that ensures timely telephonic, page and/or secure communication methods (e.g. portal) with a qualified provider that is accessible 24/7, either through a nurse call line, on-call provider or other PCP	Provide narrative of communication workflow; Create a 1- month report, log or screenshots of on-call schedule noting response times created by the practice (e.g. 30-minute response time to patient) and evidence must include patient disposition at call outcome	Improve communication capabilities by using secure communication methods (e.g. portal) or nurse call line for other non-urgent care; assures navigation to other care coordination and referrals to educational resources (e.g. diabetic education tools, navigation to patient health questionnaires, proper utilization of ED vs office visits).	Provide 3 de-identified screenshots or examples showing patient communications for non-urgent care provided after hours through use of secure communication methods or nurse call line		
Commitment to provide Same Day Appointments at Gate 2			Review hours of operation and scheduling patterns to determine most successful method of ensuring same day appointment availability Describe policy and process for same day appointments	Provide narrative on method to assess and meet demands, including the policy and workflow assignments for maintaining schedules; Measure patients seen at same day		

			Assess practice's demands for same day appointments with goal to satisfy at least 80% of demand	appointments (numerator) over patient phone calls requesting same day appointments (denominator) and improve in a 3 months period		
Commitment to providing Culturally and Linguistically Appropriate Services at Gate 2			Assess need and develop plan to address population diversity and cultural needs Engage interpretation services as applicable to the practices population needs, incl. visual or hearing impaired Print and/or electronically provide preferred language materials to patients that meet practice community needs	Practice should identify their panels by language and ethnicity for services intervention and provide a screenshot of documentation in EHR or spreadsheet/log; Provide an example of printed materials used (only if diversity population exceeds 5% of panel)		
Commitment to providing at least one Session Weekly during non-traditional Hours at Gate 3					Practice provides a minimum of one non-traditional weekly session of scheduled services defined as before 8AM or after 6PM, and/or weekends Review hours of operation and scheduling patterns to determine most	Measure the ratio of patients seen in non-traditional session(s) to patients seen during normal business hours in a 6 month period and provide narrative of how improvement was achieved

					successful course in optimization of 1 non-traditional weekly session	Provide narrative describing selection of visit types (i.e., 15-minute sick calls, Annual Physicals, post-discharge follow-ups) and time slots templated for session

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HIT MILESTONE	*Capability: Use health information technology to deliver better care that is evidence-based, coordinated, and efficient*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to Achieving Gate 2 Milestones (below) within One Year	Plan must include approach to quality measurement and care coordination tools, with steps and associated dates	Practice (with TA assistance) must submit plan for achieving Gate 2 milestones				
Commitment to utilizing Tools for Quality Measurement encompassing all Core Measures at Gates 2, 3 Commitment to Attest to Connect to HIE in Year at Gate 2 Commitment to Securing Electronic Provider-Patient Secure Messaging at Gate 3			Ability to capture, calculate and report all core measures Develop basic Information Exchange Attestation to connect to HIE in 1 year by establishing a participation agreement with their RHIO	Demonstrate Certified health information: Common Clinical Data Set, Demographics, Vital signs, body mass index, and growth charts, Problem List Clinical Quality Improvement: capture, calculate & report measures, Active Medication List, Medication Allergy List Smoking Status, Patient List Creation, Secure Messaging , View, Download and Transmit to a 3rd party	Ability to provide 24/7 remote access through health IT: Secure electronic provider-patient messaging Information Exchange, that includes reconciliation and incorporation of exchanged information using EHR technology certified to 170.314(b)(4) Enhanced Quality Improvement including Clinical Decision Support (CDS) Certified health IT for quality	Provide verification of transitions of care for all below: receive, display, and incorporate transition of care/referral summaries (including sharing advanced directives) Provide verification of Clinical Information and medication Reconciliation, Incorporate Lab Values, test results Record Immunizations and transmit to immunization registry Clinical decision support interventions that have been enabled

				Signed RHIO participation agreement	improvement, information exchange Connected to local HIE QE	Provide transmission report or letter from HIE/RHIO certifying connection

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PAYMENT MODEL MILESTONE	*Capability: Participate in outcomes-based payment models, based on quality and cost, for over 60% of the practice's patient panel*					
	GATE 1 What a practice achieves on its own, before any TA or multi-payer financial support	**Criteria for passing Gate 1**	**GATE 2** What a practice achieves after 1 year of TA, including all prior milestones	**Criteria for passing Gate 2**	**GATE 3** What a practice achieves after 2 years of TA, including all prior milestones	**Criteria for passing Gate 3**
Commitment to Value Based Contracts with APC-participating payers within 1 Year	Commitment to Value Based Contracts with APC-participating payers within 1 Year	Submit a summary list of current payers along with contract expiration dates				
Commitment to contracts for minimum FFS with P4P contracts with participating payers representing 40% of panel, with commitment to achieving 60% at Gate 2			Signed Contracts meeting criteria representing 40% of panel with commitment to achieve 60%	Report of number of patients attributed to each APC-participating payer or other reports that show reach/impact of contracts Report on total current empaneled patients		
Commitment to value-based gainsharing contracts with APC-participating payers representing 60% of panel at Gate 3					Signed Contracts meeting criteria representing 60% of panel. Numerator: Patients attributed to APC-participating payers/ Denominator: total patients attributed to practice	Report of number of patients attributed to each APC-participating payer; Report on total current empaneled patients