APC Evidence Crosswalk to NYS PCMH

Summary Guide

April 1, 2018

New York State Department of Health

INTRODUCTION TO THE EVIDENCE CROSSWALK

Effective April 1, 2018, the State Innovation Model (SIM) funded Advanced Primary Care Model (APC) will be known as the New York State Patient-Centered Medical Home Model (NYS PCMH). NYS PCMH has fortified existing principles within the NCQA PCMH model to strengthen sustainability and promote readiness for the changing climate in value-based care.

Each APC Milestone and corresponding material evidence was evaluated in contrast to corresponding NCQA Concepts, Competencies and required evidence. This exercise was to determine where, if possible, existing APC requirements could satisfy PCMH conditions to achieve NYS PCMH Recognition. This document was created as a reference guide for TAs to use in reviewing existing APC material evidence for NYS PCMH.

UNDERSTANDING THE CROSSWALK

The Crosswalk is presented according to NCQA's 6 Concept Titles, noted as "PCMH Element", along with a description of each Concept. NCQA models are characterized by core and elective criteria. Practices must meet all 52 required criteria (40 PCMH core + 12 NYS required). In addition, Practices need to earn 25 credits in elective criteria across 6 concepts. The majority (16-19) of the elective credits are earned through the 12 NYS required criteria, leaving 6-9 elective credits that must be completed to earn NYS PCMH recognition.

A Note section immediately follows each Concept to explain whether APC documentation is either "met", "not met" or is "partially met" as acceptable evidence. See definitions provided below. The Crosswalk depicts columns for the PCMH Criteria (i.e. CM or KM), with Core (PCMH and NYS) depicted by an *Asterisk. The reference page identifies where to find the information in the NCQA PCMH Standards and Guidelines (2017 Edition, Version 2). The APC Milestone Code Locator, at the end of the Crosswalk document identifies where information is located in the APC Technical Specifications document.

The next 3 columns refer to APC existing practice documentation, generally reviewed under Gate 2 criteria. These columns are identified as "APC Documents NEW, APC Documents MET, and APC Documents PARTIAL", noted under each Concept section. If appropriate documents are "met" there are a couple of things to consider. Any document submitted to or reviewed by NCQA must have the quality and quantity expected to meet their approval. Secondly, APC material evidence does not line up, in all cases, with PCMH criteria in a "check box" fashion. If documentation is "new" it means that APC does not meet the requirement and should be considered new material evidence. The "Partial" column means that some APC evidence may meet part of the criteria, however, there are several references to Gate 3, in the Comments column. If the APC practice has not achieved Gate 3, then this would generally mean that new material evidence would then be required. Also, in the Comments column, NCQA provides helpful tips and comments for what is still required beyond APC criteria to meet the evidence. Any **asterisks will correspond to content in the same row.

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TEAM-BASED CARE AND PRACTICE ORGANIZATION (TC)

- NOTE: Please use the **APC Reference Key** to identify Milestone codes listed below. Core Elements are identified by an *asterisk. Acceptable APC documentation is identified as the following: **MET**= APC documentation meets PCMH requirements; **NEW** = APC documentation does NOT meet requirement; **PARTIAL**= APC meets some criteria, additional documentation will be required; **TIPS/COMMENTS** = References location in the APC Milestone and Implementation Guide, if followed; what can be used as supplement to material evidence; and/or indicates NCQA Tips for APC documentation.

Team-Based Care and Practice Organization (TC)

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

PCMH ELEMENT TC	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
TC 01*	Pg. 31	PAR 1.1	**X**			Participation agreement will be reviewed for compliance, for TC 01, the APC Participation Agreement can serve as the PCMH Transformation practice leads required for TC 01; practice enters required details of lead personnel.
TC 02*	Pg. 31	PAR 1.2			**X**	Guidance should be updated to clearly state that all staff roles, skills and

						responsibilities are covered; organization chart is ok.

PCMH ELEMENT **TC**	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
TC 03	Pg. 32	HIT 3.5	**X**			TC 03 met by participation in APC. HIT Gate 3 aligns; the practices need to just attest to this.
TC 04	Pg. 32	PCC 2.2			**X**	Need to define structure and regular input to the documented process; materials describing a committee or governance in PFAC or Focus group with all stakeholders are necessary
TC 05*	Pg. 32	HIT 2.1			**X**	APC Practices that do not have an EHR will not meet this requirement; documentation of CEHRT is no longer required but EHR-vendor name is needed
TC 06*	Pg. 33	CMC 3.2			**X**	Need to provide a process for communication or structured care team meetings, includes Pre-visit Planning

PCMH ELEMENT **TC**	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
TC 07*	Pg. 33	PCC 2.2			**X**	Can be partially met by PCC, Gate 3; need to provide a policy around QI team activities, and meeting minutes (could also be an assigned staff role).
TC 08	Pg. 33	CMC 2.3			**X**	The behavioral health care manager must be identified and qualifications described; if this is included in the CM/CC job description it will meet criteria
TC 09*	Pg. 34	PCC 2.2		**X****		**Process and Evidence required; PCC Gate 3 may meet requirement; if not Gate 3, new criteria is needed: website, patient packets, etc., to inform patients

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KNOWING AND MANAGING YOUR PATIENTS (KM)

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Knowing and Managing Your Patients (KM)

The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services.

PCMH ELEMENT KM	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
KM 01*	Pg. 35	HIT 2.2	**X**			Met by Milestone HIT, Gate 2
KM 02*	Pg.36-37	CMC 2.4		**X**		Portions may contribute by evidence for Milestone PCC Gate 1/POP Gate 3
KM 03*	Pg. 38	CMC 2.4	**X**			Met by Milestone CMC, Gate 2
KM 04*	Pg. 39-41	POP 3.2	**X****			**B, C would meet minimum requirement but encouraged to select additional screens

PCMH ELEMENT KM	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
KM 05	Pg. 40	N/A		**X**		No acceptable APC evidence
KM 06	Pg. 42	N/A			**X**	KM 06 may be partially met with CMC Gate 3/ POP Gate 3; this is an assessment across ALL populations, not just high-risk patients; use of payer reports are not enough evidence
KM 07	Pg. 42	N/A			**X**	Needs evidence of Implementation
KM 08	Pg. 43	ATC 2.2	**X**			Met by ATC Gate 3
KM 09*	Pg. 44	ATC 2.2			**X**	Some practices have difficulty looking at least one other aspects of diversity; if the APC Guide is clearly followed under Gate 2 HIT, pg. 42 then partially met
KM 10*	Pg. 44	ATC 2.2	**X**			KM 10 is met by ATC Gate 2
KM 11*	Pg. 45	POP 3.1, CMC 3.2, POP 3.2			**X**	KM 11 Portions may be met by CMC Gate 3/POP Gate 3; needs evidence of Implementation for B, C
KM 12*	Pg. 46	HIT 3.6, POP 3.1			**X**	KM 12 may be met with POP Gate 3 and HIT Gate 3 include patient lists; registries and pop outreach also apply

PCMH ELEMENT KM	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
KM 13	Pg. 46	N/A		**X**		No acceptable evidence in APC
KM 14*	Pg. 47	N/A		**X**		KM 14 is met if 80% threshold was met; APC did not require 80%
KM 15*	Pg. 47	CMC 3.2, HIT 2.2			**X**	KM 15 may be met by HIT Gate 2; must meet 80%
KM 16	Pg. 47	CMC 3.2		**X****		**KM 16 may be met by CMC Gate 3 if incorporated into the Care Plan or Patient Summary; verifying that the patient understands use of Rx
KM 17	Pg. 48	CMC 3.6			**X****	**If medication is reviewed with the patient as part of the care plan or Patient Summary; patient understands use of Rx, medication barriers and goals
KM 18	Pg. 48	N/A	****X**			**Met by NYS Requirement for iSTOP; show proof
KM 19	Pg. 48	CMC 3.3			**X**	KM 19 may be met by CMC Gate 3; may satisfy through care coordination reports and/or participating health plan data that provide pharmacy utilization; must resubmit APC documents for consideration

PCMH ELEMENT KM	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
KM 20*	Pg.50	HIT 3.6, POP 3.3	**X**			KM 20 is met by four Clinical Decision Support (CDS) interventions in POP Gate 3 and HIT Gate 3
KM 21*	Pg. 51	POP 3.3	**X**			KM 21 is met only by POP Gate 3
KM 22	Pg. 51	POP 3.3	**X**			KM 21 is met only by POP Gate 3
KM 23	Pg. 52	N/A		**X**		No acceptable evidence in APC
KM 24	Pg. 52	CMC 2.2	**X**			KM 24 is met by CMC Gate 2
KM 25	Pg. 52	N/A			**X**	KM 25 is met with POP Gate 3 and evidence of implementation
KM 26	Pg. 53	POP 3.3			**X**	KM 26 may be met by POP Gate 3; relevant resources must be identified and reflect the population's needs (identified in KM 21)
KM 27	Pg. 53	POP 3.3		**X****		**KM 27 may be met by POP Gate 3 if the practice can demonstrate assessment and review of patient feedback
KM 28	Pg. 53	N/A		**X**		KM 28 can be further supported by POP criteria at Gate 3

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PATIENT-CENTERED ACCESS AND CONTINUITY (AC)

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Patient-Centered Access and Continuity (AC)

The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

PCMH ELEMENT **AC**	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
AC 01*	Pg. 54	ATC 1.1		**X**		Needs evidence of Implementation: patient survey, interview, comment box or portal input
AC 02*	Pg. 54	ATC 2.1			**X**	Policy, process and must be available for same day appointments
AC 03*	Pg. 53	ATC 2.1	**X**			Requirement met at Gate 2
AC 04*	Pg. 56	ATC 1.1			**X**	Needs evidence of implementation and goal setting

AC 05*	Pg. 56	ATC 3.3			**X**	See APC Guide; and provide documented process

PCMH ELEMENT	**PCMH Standards and Guidelines* Page Reference**	**APC Milestone Code Locator**	**APC Document(s) MET**	**APC Document(s) NEW**	**APC Document(s) PARTIAL**	**NCQA TIPS AND COMMENTS**
AC 06	Pg. 57	N/A		**X**		Needs process and report: Pg. 66, APC Guide AND evidence for electronic appointment types
AC 07	Pg. 57	HIT 3.2			**X**	Need a more structured portal that allows patients to obtain referral information, refills, etc.
AC 08*	Pg. 57	ATC 2.1, HIT 3.2			**X** A report is required, as partial	Needs clinical response time goal: process and policies and report
AC 09	Pg. 58	ATC 2.2			**X**	Must stratify population; access disparity assessment in addition to measures in APC; Supplemental: APC Guide, pgs. 19,34, 40 M6, Gate 2
AC 10*	Pg. 59	CMC 2.3			**X**	A process is needed, as well as evidence. CMC Gate 3/VBP Gate 2 may contribute.; AC 10 met by CMC Gate 2 with a process
AC 11*	Pg. 59	CMC 2.3		**X**		Needs evidence of Implementation; evidence of goal for visits with own provider (continuity)
AC 12*	Pg. 59	ATC 1.1		**X**		Needs documented process

PCMH ELEMENT **AC**	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
AC 13	Pg. 60	CMC 3.1, VBP 1.1		**X**		Documented process and report are required; APC Milestone 4, Gate 3 can contribute
AC 14	Pg. 60	CMC 3.1, VBP 1.1			**X**	Need a documented process to review and update/reconcile; Milestone 7, VBP may contribute

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CARE MANAGEMENT AND SUPPORT (CM)

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Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

PCMH ELEMENT CM	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
CM 01*	Pg. 61	CMC 3.1	**X** NY APC practices will meet with CM 03			CM 01 may be met by CMC Gate 3
CM 02*	Pg. 62	CMC 3.1	**X**			CM 02 met by CMC Gate 3
CM 03*	Pg. 62	CMC 3.3	**X**			CM 03 met by CMC Gate 3; applies a comprehensive risk - stratification process to entire patient panel

PCMH ELEMENT TC	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
CM 04*	Pg. 61	CMC 3.2	**X**			CM 04 met by CMC Gate 3
CM 05*	Pg. 62	CMC 3.2			**X**	Only report is met; patient examples required if using the Record Review Workbook (RRW); for example, patient literacy and language preference is recommended
CM 06	Pg. 62	CMC 3.3			**X**	CM 06 is met with CMC Gate 3; only satisfies report, not record review and patient examples
CM 07	Pg. 62	CMC 3.1	**X**			CM 07 is met by CMC Gate 3; could be satisfied through report or the RRW and patient examples in CM 06
CM 08	Pg. 65	CMC series for background on APC Care Plan development		**X**		Care Plans must include a Self-Management Plan; examples alone not sufficient; must include examples and report or chart review
CM 09*	Pg. 65	CMC 3.2	**X**			CM 09 is met by CMC Gate 3; note percentage of patients with a care plan and include evidence of shared care planning

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CARE COORDINATION AND CARE TRANSITION (CC)

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Care Coordination and Care Transitions (CC)

The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

PCMH ELEMENT CC	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
CC 01*	Pg. 66	HIT 3.6		**X**		Requires lab and imaging flagging and follow up; supporting documentation may be met through HIT Gate 3
CC 02	Pg. 67	N/A		**X**		May be met by HIT Gate 3 if Newborn screens are present and there is evidence of Implementation
CC 03	Pg. 67	POP 3.2			**X**	May be met by POP Gate 3; those that meet KM 20 meet this element

PCMH ELEMENT CC	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
CC 04*	Pg. 68-69	CMC 2.4, CMC 3.7			**X**	Needs process along with CMC Gate 2/Gate 3 reports; partially met if there is a referral template and (A.B.C.) are built into Care Compacts and clearly covered; this can sometimes be met by EHR functionality
CC 05	Pg. 69	POP 3.2			**X**	Clinical Decision Support (CDS) referrals needed; may be met by POP Gate 3; can be met by KPM 20; can be met by chronic conditions care compact
CC 06	Pg. 70	CMC 3.5	**X**			Met by CMC Gate 3; include referral responses; care compacts
CC 07	Pg. 70	CMC 3.4			**X**	May be met by CMC Gate 3; use of payer reports supports this requirement; more of a structured portal to exchange needed referral information is required; making clear to patients that it can be uses for these purposes

PCMH ELEMENT CC	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
CC 08*	Pg. 70	CMC 3.4, CMC 3.5	**X**			CMC Gate 3 meets requirement.
CC 09*	Pg. 71	CMC 2.4	**X**			CMC Gate 2 meets requirement
CC 10	Pg. 71	CMC 3.7	**X**			Met by CMC Gate 3
CC 11	Pg. 72	CMC 3.4	**X**			Met by CMC Gate 3
CC 12	Pg. 72	CMC			**X**	May be met by CMC Gate 3; need to identify who is responsible in a care compact; see APC Implementation Guide Pg. 63 for additional support
CC 13	Pg. 72	N/A		**X**		May be met by POP Gate 3 if treatment options and cost are indicated; if there is evidence of intake discussions with patients concerning the requirement
CC 14*	Pg. 73	CMC 3.3			**X**	Needs a report plus CMC 3.3
CC 15*	Pg. 73	CMC 3.6			**X**	Needs additional process for communication to facilities (hospital, ED's, etc.); somewhat addressed in CM/CC in APC Implementation Guide, Pg. 26.
CC 16*	Pg. 73	CMC 3.6	**X**			Met by CMC Gate 3

PCMH ELEMENT CC	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
CC 17	Pg. 74	HIT 3.2, HIT 3.4, HIT 3.5			**X**	Requirement is met with process and evidence of communication for patients seen in an acute care setting, may be met by HIT Gate 3 if real time alerts are present via QEs or facilities
CC 18	Pg. 74	HIT 2.3			**X**	Requirement is met with process and evidence of communication for admitted patients; May be met by HIT Gate 3; real time information must be exchanged with facilities or a practice is connected via a QE
CC 19*	Pg. 74	CMC 3.6	**X**			Met with CMC Gate 3 including process;
CC 20	Pg. 75	CMC 3.2			**X**	May be met with an appropriate patient care plan that may be included under CMC Gate 3; should include specific subset of care plans for children transitioning to another provider or similar care
CC 21*	Pg. 76	HIT 2.3			**X**	Meets minimum of 1 credit for HIE, QE/RHIO participation with documentation

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PERFORMANCE MEASUREMENT & QUALITY IMPROVEMENT (QI)

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Performance Measurement and Quality Improvement (QI)

The practice establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

PCMH ELEMENT QI	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
QI 01*	Pg. 77	HIT 2.3	**X**			Met by HIT Gate 2; Suggest we identify measure type for all required measure reporting to assure all categories are covered for QI 01 and QI 02; relevant measures will be identified.
QI 02*	Pg. 77	HIT 3.3			**X**	May be met by HIT Gate 3, with suggestions: include cost and care coordination measures

PCMH ELEMENT QI	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
QI 03*	Pg. 78	ATC 2.1			**X**	May be met by ATC Gate 2; need to demonstrate review of the report with staff to measure availability of appointment types
QI 04*	Pg. 78-79	PCC 2.2	**X**			May be met by PCC Gate 2 if Survey generates a report; qualitative data also needed for B.
QI 05	Pg. 79	PCC 3.2		**X**		May be partially met by CMC Gate 3 if practice can identify disparity through either clinical measures and patient experience; break a measure into a subgroup
QI 06	Pg. 80	PCC 2.2		**X**		Requirement is for a benchmarked survey: if practice using CAHPS for APC and benchmarking then acceptable.
QI 07	Pg. 80	CMC 3.1, PCC 2.2		**X**		May be met by CMC Gate 3; practice must identify where patients in a vulnerable group have a different experience for QI of that group and get the data; must show QI over baseline for improvement

PCMH ELEMENT QI	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
QI 08*	Pg. 81	HIT 2.1, CMC 2.4			**X**	Portions may be met by CMC Gate 2; 3 measures in at least those 3 categories listed in competency, i.e., preventive, BH, acute care; include as specific categories; See NCQA QI Worksheet (QIWS) and QI 01
QI 09*	Pg. 82	N/A		**X** See NCQA QIWS for QI 08 - 14		Requirement is for a QI report; includes focus on interventions, and goals; see link provided by NCQA on their website for meeting QI 09
QI 10*	Pg. 82	ATC 2.1			**X**	May be met by reports and actions for ATC Gate 2; different types of appts: see QI 03 urgent routine school physicals, Medicare well-check; supported by pg. 34 in APC Implementation Guide; add in language about the visits that should be covered
QI 11*	Pg. 83	PCC 2.2			**X**	May be met by reports and actions for PPC Gate 2; this is only the measure; requires goals; set goals and integrate some type of PDSA cycle

PCMH ELEMENT QI	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
QI 12	Pg. 83	HIT 2.1			**X**	May be met by reports and actions for HIT Gate 2; must show QI over baseline for credit; see QI 11
QI 13	Pg. 83	ATC 2.2			**X**	May be met by reports and actions for ATC Gate 2; APC material evidence valid for reporting only
QI 14	Pg. 83	PCC 3.2		**X**		May be partially met by reports and actions for PCC Gate 3; must show QI over baseline for credit; see QI 13
QI 15*	Pg. 84	CMC 3.1, CMC 2.3, CMC 3.3		**X**		Requirement is process of reporting; review dashboard and engage with staff; demonstration of practice or physician level reporting is required
QI 16	Pg. 84	HIT 2.2, HIT 3.1, HIT 3.2, HIT 3.3			**X**	May be met by HIT Gate 3

PCMH ELEMENT QI	PCMH Standards and Guidelines* Page Reference	APC Milestone Code Locator	APC Document(s) MET	APC Document(s) NEW	APC Document(s) PARTIAL	NCQA TIPS AND COMMENTS
QI 17	Pg. 84	PCC 2.2	**X**			Met by VBP Gate 2
QI 18	Pg. 85	CMC 2.4	**X**			Met by CMC Gate 2; measures are included in the Core Measure Set
QI 19*	Pg. 85	VBP 2.1	**X** For A only			Met by VBP Gate 2

APC MILESTONE CODE LOCATOR

APC Element	Brief Description	Category
PAR 1.1	APC participation agreement	**Participation**
PAR 1.2	Practice Assessment Survey	**Participation**
PAR 1.3	Designated change agent / practice leaders	**Participation**
PAR 1.4	Participation in TA Entity APC orientation	**Participation**
PAR 1.5	Commitment to achieve gate 2 milestones in 1 year	**Participation**
PAR 2.1	Participation in TA Entity activities and learning (if electing support)	**Participation**
PCC 1.1	Process for Advanced Directive discussions with all patients	**Patient Centered Care**
PCC 2.1	Advanced Directive discussions with all patients >65	**Patient Centered Care**
PCC 2.2	Plan for patient engagement and integration into workflows within one year	**Patient Centered Care**
PCC 3.1	Advanced Directives shared across medical neighborhood, where feasible	**Patient Centered Care**
PCC 3.2	Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base developed in Gate 2, where applicable)	**Patient Centered Care**
POP 3.1	Participate in local Prevention Agenda activities	**Population Health**
POP 3.2	Annual identification and outreach to patients due for preventive or chronic care management	**Population Health**
POP 3.3	Process to refer to self-management and community-based resources	**Population Health**

CMC 1.1	Commitment to developing care plans in concert with patient preferences and goals	**Care Management/Coordination**
CMC 1.2	Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year	**Care Management/Coordination**
CMC 2.1	Identify and empanel highest-risk patients for CM/CC	**Care Management/Coordination**
CMC 2.2	Process in place for Care Plan development	**Care Management/Coordination**
CMC 2.3	Plan to deliver CM / CC to highest-risk patients within one year	**Care Management/Coordination**
CMC 2.4	Behavioral health: Evidence-based process for screening, treatment where appropriate[1], and referral	**Care Management/Coordination**
CMC 3.1	Integrate high-risk patient data from other sources (including payers)	**Care Management/Coordination**
CMC 3.2	Care plans developed in concert with patient preferences and goals	**Care Management/Coordination**
CMC 3.3	CM delivered to highest-risk patients	**Care Management/Coordination**
CMC 3.4	Referral tracking system in place	**Care Management/Coordination**
CMC 3.5	Care compacts or collaborative agreements for timely consultations with medical specialists and institutions	**Care Management/Coordination**
CMC 3.6	Post-discharge follow-up process	**Care Management/Coordination**
CMC 3.7	Behavioral health: Coordinated care management for behavioral health	**Care Management/Coordination**
ATC 1.1	24/7 access to a provider	**Access to Care**
ATC 2.1	Same-day appointments	**Access to Care**
ATC 2.2	Culturally and linguistically appropriate services	**Access to Care**
ATC 3.1	At least 1 session weekly during non-traditional hours	**Access to Care**

HIT 1.1	Plan for achieving Gate 2 milestones within one year	**Health Information Technology**
HIT 2.1	Tools for quality measurement encompassing all core measures	**Health Information Technology**
HIT 2.2	Certified technology for information exchange available in practice for	**Health Information Technology**
HIT 2.3	Attestation to connect to HIE in 1 year	**Health Information Technology**
HIT 3.1	24/7 remote access to Health IT	**Health Information Technology**
HIT 3.2	Secure electronic provider-patient messaging	**Health Information Technology**
HIT 3.3	Enhanced Quality Improvement including CDS	**Health Information Technology**
HIT 3.4	Certified Health IT for quality improvement, information exchange	**Health Information Technology**
HIT 3.5	Connection to local HIE QE	**Health Information Technology**
HIT 3.6	Clinical Decision Support	**Health Information Technology**
VBP 1.1	Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	**Payment Model**
VBP 2.1	Minimum FFS with P4P^2 contracts with APC-participating payers representing 60% of panel	**Payment Model**
VBP 3.1	Minimum FFS + gainsharing 3 contracts with APC-participating payers representing 60% of panel	**Payment Model**