APCM Care STEPs Report

***Care** and **S**ervices **T**hat **E**ngage **P**atients*

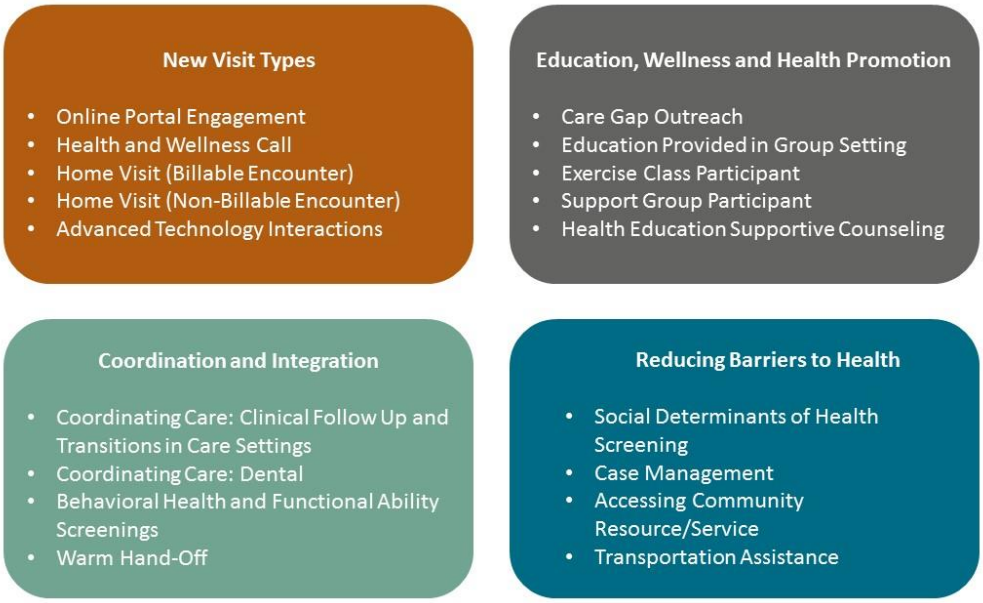
In the Alternative Payment and Advanced Care Model (APCM) program, collaboratively developed by the Oregon Health Authority, Oregon Primary Care Association and participating Oregon Federally Qualified Health Centers, patient access to health care is no longer defined only by the traditional face-to-face office visit.

The goal of the Care STEPs documentation system is to demonstrate the range of ways in which health center teams are providing access to services and value to patients. Care STEPs data are collected and submitted quarterly so that OHA can better understand the non-billable and non-visit-based care and services that are being delivered as the Patient-Centered Primary Care Home model advances under APCM.

A Care STEP is a specific direct interaction between the health center staff and the patient, the patient's family or authorized representative(s) through in-person, digital, group visits, or telephonic means. There are currently 18 Care STEPs, grouped into four categories: 1) New Visit Types, 2) Education, Wellness and Health Promotion, 3) Coordination and Integration, and 4) Reducing Barriers to Health the definitions are listed below.

The definitions and guidance on when to document each Care STEP is provided below. If more than one Care STEP is conducted during a single interaction with a patient, document all of the Care STEPs that correspond with the services provided to the patient. For example, a nurse is conducting care gap outreach to patients with diabetes who are due for an HbA1c test. The nurse initiates a telephone call with the patient and discusses the patient's gaps in care. The patient would like to come to the clinic to complete the lab test, but does not have the money for bus fare. The nurse helps to arrange transportation for the patient. During this call, the nurse asks the patient about their top concerns in managing their diabetes and the patient discloses sometimes running out of money to buy groceries. The nurse creates a referral for the patient to the local food pantry and creates a plan to follow up with the patient the following week to see if the patient was able to access the local food resource services. In this call, the nurse should document the completion of three Care STEPs: 1) Care Gap Outreach, 2) Transportation Assistance, and 3) Accessing Community Resource/Services.

Care STEPs: Categories



Care STEPs: Details

New Visit Types		
Care STEP	**Definition**	**Use**
Online Portal Engagement	Patient and/or family communicate with members of the care team using a web portal application within the electronic health record system that allows patients to connect directly with their provider and care team securely over the internet.	This Care STEP should be counted when a message is sent from the patient or the patient's care team sends a message to them.
Health and Wellness Call	Health center provider or qualified health professional[1] speaks to the patient or family/representative over the telephone about health and/or wellness status to discuss or create care plan, treatment options, and/or health promotion activities (with the exception of tobacco cessation or maternity case management[1])	This Care STEP should be counted when health center staff member speaks with patient or family/representative about health and/or wellness status AND discusses or creates care plan OR discusses treatment options OR discusses health promotion activities.

[1] Tobacco cessation and maternity case management are excluded from this category because these types of telephone calls are billable encounters, as long as they include all of the same components of a

New Visit Types		
Care STEP	**Definition**	**Use**
		Standard clinical operations such as appointment reminders and calls supporting other administrative processes should not be recorded.
Home Visit (non-billable)	Health center staff visit the patient's home for reasons unrelated to assessment, diagnosis, treatment, or Maternity Case Management. Non-billable home visits include but are not limited to: A community health worker visiting patient's residence to support the family or a clinical pharmacist visiting to assist with medication management and reconciliation.	This Care STEP should be counted upon completion of the home visit as defined in the definition section.
Home Visit Encounter	Health center staff conduct a billable home visit. The Division considers a home visit for assessment, diagnosis, treatment or Maternity Case Management as an encounter [2].	This Care STEP should be counted when a health center provider or other qualified health professional conducts a billable home visit at a patient's residence or facility for assessment, diagnosis, treatment, or Maternity Case Management.
Advanced Technology Interactions	This Care STEP includes telemedicine encounters, as well as other types of interactions supported by technologies not historically used for providing health care, such as text messaging or the use of smartphone applications for remote patient monitoring or other health promotion activities.	This Care STEP should be counted when: 1) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a medical practitioner located in a distant site and the client being evaluated and located in an originating site that is a billable telemedicine encounter according to

face-to-face visit, in accordance with OAR 410-147-0120 Section 4. Retrieved from http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

[2] Details relating to billable home visit encounters can be found in OAR 410-147-0120, section 10(n) and can be accessed at: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

New Visit Types		
Care STEP	**Definition**	**Use**
		OAR[3] are conducted OR when a non-billable interaction between a member of the health care team and the patient using videoconferencing takes place. 2) Health center staff uses a non-traditional technology, such as text messaging or smartphone application, to interact with patients regarding their health and wellness status OR discuss their care plan or treatment options OR provide health promotion based on the patient's health status or risk factors. Outreach efforts where the patient does not reply may not be counted.

Education, Wellness and Health Promotion		
Care STEP	**Definition**	**Use**
Care Gap Outreach	Health center staff identify gaps in care for their empaneled patients and speak with patients or family/representative to help them access the appropriate health promotion, preventive or chronic disease management care and services.	This Care STEP should be counted when health center staff have spoken in-person or over the phone with patient or family/representative regarding gaps in care.
Education Provided in Group Setting	Patient attends an education group related to health promotion activities (such as	This Care STEP should be counted when the health center verifies that the individual

[3] Details relating to billable telemedicine encounters can be found in OAR 410-130-0610 and accessed at: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_130.html.

Education, Wellness and Health Promotion		
Care STEP	**Definition**	**Use**
	parenting/pregnancy classes, health fairs, and teaching kitchens/healthy cooking classes) provided by health center staff or affiliated group.[4]	patient attended the education class/event provided by the health center or affiliated group. Verification may come from the patient.
Exercise Class Participant	Patient attends an exercise class (such as a low-impact walking group, yoga, Zumba, or Tai Chi) provided by the health center or affiliated group.[4]	This Care STEP should be counted when the health center verifies that the individual patient attended the exercise class/event provided by the health center or affiliated group. Verification may come from the patient.
Support Group Participant	The patient attends a support group for people with common experiences and concerns, who provide emotional and moral support for one another, hosted by the health center or affiliated group.[4]	This Care STEP should be counted when health center staff have verified patient attended a support group hosted by their health center or referred to by the health center. Verification may come from the patient.
Health Education Supportive Counseling	Services provided by a physician or other qualified health care professional[5] to an individual or family, in which wellness, preventive disease management, or other improved health outcomes are attempted through discussion with patient or family. Wellness or preventive disease management counseling will vary with age and risk factors and may address such issues as family problems, social circumstances, diet and exercise, substance use, sexual practices, injury prevention,	This Care STEP should be counted when health center staff engages in the activities described in the definition.

[4] The health center must have a contract, MOU or other written agreement with the affiliated group to establish access for health center patients in order to count services provided by the affiliated group in this Care STEP category.

[5] Qualified health professional is any health care professional providing services within their scope of practice, either under their own licensure, or working under the supervision requirements of an overseeing provider's license. Definition retrieved from OAR 410-147-0120 Section 11, http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

Education, Wellness and Health Promotion		
Care STEP	**Definition**	**Use**
	dental health, and diagnostic and laboratory test results available at the time of the encounter.	

Coordination and Integration		
Care STEP	**Definition**	**Use**
Coordinating Care: Clinical Follow-up and Transitions in Care Setting	Health center staff speaks with patient or family/representative regarding the patient's recent care at an outside health organization (ER, hospital, long-term care facility, etc.) to: 1) Arrange a follow-up visit or other CARE STEP at the health center, or 2) Speaks with patient to update care plan and educate on preventive health measures, or 3) Assists patient with a transition in their care setting.	This Care STEP should be counted when health center staff have verified the patient received or needs to receive health services from a different provider, and completed 1, 2, or 3 listed in the definition section.
Coordinating Care: Dental	During primary care visit, patient and health center staff identify that patient has dental health care needs, and coordinates with dental professionals by assistance with dental appointment set-up or follows up with patient about dental health care needs.	This Care STEP should be counted when health center staff have confirmed that the primary care provider set-up a dental appointment and/or has followed up with the patient about their dental health care needs.
Behavioral Health and Functional Ability Screenings	Health center staff facilitates the completion of standardized screening tools that assess patient's needs or status relating to behavioral health, functional ability and quality of	This Care STEP should be counted when completion of the screening process has been initiated to support care and service planning in collaboration with the patient.

Coordination and Integration		
Care STEP	**Definition**	**Use**
	life in order to organize next steps in a care plan. Screening tools include behavioral, mental health, developmental, cognitive or other functional screening tools, either through interview or patient self-administration of a screening form.	
Warm Hand-off	Health center provider or health professional conducts a face-to-face introduction for the patient to a provider or health professional of a different health discipline (e.g. primary care physician introduces patient to a behavioral health consultant or community health worker).[6]	This Care STEP should be counted when the patient is successfully introduced to the second provider or health professional.

Reducing Barriers to Health		
Care STEP	**Definition**	**Use**
Social Determinants of Health Screening	Health center staff facilitate the completion of a Social Determinants of Health screening questionnaire with the patient, either through interview or patient-self administration of a screening form.	This Care STEP should be counted when the screening process has been initiated to support care and service planning in collaboration with the patient.
Case Management	Case management is a process in which a provider or another qualified health care professional[7] is responsible for direct care of a patient and, additionally, for coordinating,	This Care STEP should be counted, once a case manager is assigned to the patient, for all interactions where the case manager directly interacts with the patient or

[6] Based on the SAMHSA-HRSA Center for Integrated Health Solutions definition of a Warm Handoff. Retrieved from http://www.integration.samhsa.gov/glossary#w.

[7] Qualified health professional is any health care professional providing services within their scope of practice, either under their own licensure, or working under the supervision requirements of an overseeing provider's license. Definition retrieved from OAR 410-147-0120 Section 11, http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_147.html.

Reducing Barriers to Health		
Care STEP	**Definition**	**Use**
	managing access to, initiating, and/or supervising other health, social or other kinds of services needed by the patient. In order to use this Care STEP category, the health center must be able to identify who the assigned case manager is in the patient health record.	family/representative relating to direct care, coordination of care, managing patient's access to care or initiation and/or supervision of other health care services needed by the patient.
Accessing Community Resource/Service	Patient or family/representative is educated on available resources in their community based on a presenting need (such as assisting with immigration paperwork, finding domestic violence resources, obtaining legal services, medication assistance program registration, financial assistance, donations including clothing, infant supplies, medical equipment, prostheses, assistance finding employment, education opportunities, shelter) AND health center staff refers or connects the patient to the resource/service.	This Care STEP should be counted when health center staff educates the patient and/or family on available resources AND refers/connects the patient to the resource
Transportation Assistance	Health center provides direct assistance to a patient by a staff member or contractor to arrange or provide transportation resources and services to reduce access barriers for the patient.	This Care STEP should be counted after staff identify patient has an access barrier in the realm of transportation AND delivers the resource/service that will reduce the transportation barrier.