

# Colorado State Innovation Model (SIM)

## Practice Milestone

## Implementation Guide

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## Summary

The State of Colorado will receive up to \$65 million over a four year period from the Center for Medicare and Medicaid Innovation (CMMI) to implement and test its State Healthcare Innovation Plan. Colorado's plan, entitled "The Colorado Framework," creates a system of clinic-based and public health supports to spur innovation that will improve the health of Coloradans.

The Colorado Framework builds on work already underway in the state, especially the Comprehensive Primary Care Initiative (CPCI). The SIM initiative adopts many high value primary care activities of CPCI like team-based care, care management, and data driven improvement. The Colorado Framework adds several key components. The most prominent include an emphasis on integrated behavioral health services, the inclusion of pediatric practices, and a broader definition of primary care practices to include behavioral health centers. More information about the SIM award can be found at <http://www.coloradosim.org/>.

This Implementation Guide was developed as a resource for primary care practices and community mental health centers participating in SIM, along with their supporting Practice Transformation Organizations (PTO's), Practice Facilitators (PF's), Clinical Health Information Technology Advisors (CHITA's), and Regional Health Connectors (RHC's). This guide provides a description of the SIM Cohort 1 Milestones and recommendations on how to meet the objectives described in the milestones. A toolkit of additional materials and resources to help participants educate themselves as they undertake the work of SIM accompanies this Implementation Guide with links referenced throughout.

## Acknowledgements

The Colorado SIM Milestone Implementation Guide, SIM Toolkit, Milestone Activity Inventory, and the Practice Transformation Organization (PTO) training components were developed by a large group of engaged stakeholders. The following group of individuals dedicated considerable time and effort to the creation of these resources.

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## Introduction

### *Background - The Triple Aim, Payment Reform and Integrating Behavioral Health*

Health care in the United States is changing. The Affordable Care Act (ACA) is encouraging health care reform through Medicare and Medicaid and commercial health plans are following the lead of the ACA. The target has been summarized as the Triple Aim— better health of populations, improved patient experience of care, and reduced per capita costs.<sup>1</sup> Achieving the Triple Aim depends on “a foundation of high-performing primary care.” Health care payment models are beginning to change to promote the Triple Aim and seek to reward improved outcomes for patients and lower total cost of care. Instead of paying for volume (fee-for-service for the number of patient visits or procedures), there is an ongoing shift toward paying for value—better outcomes for populations of patients while reducing costs. Primary care medical homes will have to prepare to meet the Triple Aim and for aligned payment reforms. The SIM initiative will assist medical homes to develop new skills and processes to improve the health of their patients and prepare for these changes in payment.

Many patterns of care will need to be reengineered to achieve the Triple Aim including repairing the dysfunctional divide between behavioral health and physical health. This split, entrenched in policy, health systems, and cultural expectations, results in poor outcomes and perpetuates a damaging stigma towards patients dealing with behavioral health issues. The Colorado Framework builds upon a strong national movement in health care to integrate care of behavioral health with physical health within primary care medical homes and community mental health center based health homes.

In primary medical care we think of a continuum of services: preventive counseling (anticipatory guidance), screening, health promotion, early intervention, management of acute problems, management of chronic problems, referral to specialists for care of certain chronic problems (with shared care between primary care and specialist), and coordination of care. When behavioral health is integrated within the primary medical care setting, the same continuum can be provided: preventive counseling on behavioral issues that promotes health and well-being, behavioral health screening and identification that enables early intervention, management of acute and sub-clinical problems, management of chronic problems including substance abuse, behavioral counseling for people with chronic medical problems to help them manage and adapt to their chronic illness, and coordination of care for behavioral health issues. For younger patients, behavioral health services may focus more on prevention of disturbance, disorder, and disease, with particular attention paid to early identification of risk factors and delays or difficulties and to ameliorating distress when it first emerges and begins to impair functioning. For older adults, or chronically ill patients, the focus may be more on management of chronic physical and behavioral health conditions, along with continued prevention and screening.

Integration of physical and behavioral health within one clinical care setting enhances whole-patient care by ensuring that fewer people are lost in the process of referral to external services, difficulties are identified earlier and interventions are initiated sooner, and overall care is better coordinated. Additionally, there is potential to reduce total cost of care as many routine behavioral health issues can be addressed from within primary care, without the need for costly referral to external subspecialists. For patients, integrated behavioral health services often enhance the patient experience because of convenience of receiving comprehensive care in one clinical setting and as the result of improved communication between treating providers. The SIM initiative aims to assist medical homes in moving along the continuum toward full integration of medical and behavioral care within the medical home setting.

### ***SIM Practice Transformation Milestones: Organizing Frameworks***

SIM Practice Transformation Milestones reflect common attributes of high-performing primary care practices. They are organized based on a well-recognized framework, [Bodenheimer's "10 Building Blocks of High-Performing Primary Care."](#)<sup>2</sup> These building block concepts are consistent with themes articulated in other published frameworks including the Joint Principles of the Patient-Centered Medical Home (PCMH),<sup>3</sup> various medical home recognition standards, the Change Concepts for Practice Transformation,<sup>4</sup> University of Utah's Care by Design,<sup>5</sup> and published research on practice transformation.<sup>6,7</sup>

Building Block 1, Engaged Leadership, describes the importance of engaging the leadership of the practice, ensuring there is a team focused on SIM rather than just one individual, and helping that team create a practice-wide vision with concrete goals and objectives. The activities and skills promoted in SIM need to become part of the practice culture. This building block also describes how to arrange for the practice to complete a semi-annual practice assessment, how to introduce the practice to concepts of integrated behavioral health, and how to create a budget for SIM related activities.

Building Block 2, Data-Driven Improvement, focuses on the importance of data, the use of data to drive improvement in a practice, and different approaches to ensure that the practice's computer-based technology can effectively meet this objective. A practice can improve the health of patients only if they can collect data, understand it and track changes over time. The practice will learn how to access and understand their data, establish baseline data and use quality improvement methods to improve outcomes.

Building Block 3, Empanelment, assists the practice in understanding the importance of empanelment and how to develop systems and procedures to ensure patients are assigned to, and actually see, their provider or care team. Empanelment is the method for understanding who is in the provider's or team's

population (capturing the denominator), which is key to measuring outcomes. The practice will learn how to monitor empanelment and reconcile patient attribution with payer records.

Building Block 4, Team-Based Care, promotes team-based care and provides ways to ensure all staff are working at the top of their abilities in a coordinated fashion, improving efficiency, staff and patient satisfaction, and health outcomes.

Building Block 5, Patient-Team Partnership, promotes the use of a variety of methods for practices to work closely with their patients to improve their health: tools to enable them to better self-manage their or their child's conditions; processes and material to encourage patients and families to share decision-making with their provider; methods to enable patients and families to give feedback and input into the practice (surveys or patient advisory groups); and ways to regularly share information with patients about the practice. Each of these elements improves outcomes and the patient experience.

Building Block 6, Population Management, helps the practice develop skills in population management including developing registries, risk stratification, monitoring and managing the patient registries, screening specific populations and providing early intervention, and care management activities for specific risk groups. Each of these techniques add to the team's ability to improve the outcomes for specific groups of patients.

Building Block 7, Continuity of Care, focuses on strategies for tracking, improving and ensuring continuity of care within the primary medical home. Outcomes, cost and patient satisfaction all improve when patients receive the majority of their primary care from a specific primary care provider or team. As patients and their families identify and understand the importance of continuity, a trusting relationship is formed.

Building Block 8, Prompt Access to Care, involves coaching on methods to improve access to prompt care and routine communication with the practice. Outcomes improve when patients receive care from a provider who has direct access to the patient's current electronic health record (EHR) and when patients and their families engage with and receive timely, up-to-date communication from their practice.

Building Block 9, Comprehensiveness and Care Coordination, focuses on strategies for improving coordination of care within the practice, with specialists, and with other institutions or community resources, including hospitals and emergency departments. This building block describes coaching methods and tools to improve communication about patients and the coordination of their care to ensure it is effective and efficient.

Building Block 10, Integration and Compensation Reform, focuses on three capabilities that are an important part of the SIM framework for the future of healthcare in Colorado: integrating behavioral health into primary care or primary care into community mental health centers, adapting to payment from value-based alternative payment methods that reward population management, and partnering with community-based resource organizations to improve health.

The other framework used extensively throughout the Colorado SIM Milestone Implementation Guide and its activities is a model for conceptualizing the categories of collaboration between medical providers and behavioral health providers. It is borrowed from the extensive work on integration promoted by the [Center for Integrated Health Solutions Sponsored by SAMHSA-HRSA](#) and the [AHRQ Academy for Integrating Behavioral Health in Primary Care](#). Both organizations describe a continuum of integration between behavioral health and primary medical care.

There are three general forms of integration:

- Coordinated Care - behavioral and medical providers practice in different locations but may collaborate and coordinate care between their two practices by having preferred providers and referral sources and opportunities for communication between the settings (not necessarily about specific patients).
- Co-located Care - both types of providers deliver traditional outpatient behavioral health and medical care separately but their offices are housed in the same location.
- Integrated Care - behavioral health and primary medical care providers share patients/caseloads and develop treatment and care plans together, consult on a real-time basis while the patient is being seen at the clinic setting, and provide integrated care as a team.

A more detailed version of the continuum of integrated care models can be found at the [SAMHSA-HRSA Center for Integrated Health Solutions](#) website. Definitions and information on the concepts of integrated behavioral health can be found at in the [Lexicon for Behavioral Health and Primary Care Integration](#).

### ***General Philosophy of SIM***

Of course different patient populations will have different needs and the focus of both primary care medical providers and behavioral health providers will shift based on the target population. For example, in early childhood populations where the vast majority are basically healthy, the focus is on both medical and behavioral preventive counseling and anticipatory guidance. This includes strategies like screening, identification, and referral to early intervention services when risk factors, delays, or needs are identified. Additionally for children, screening processes, interventions, and external referrals are often focused on the family unit rather than just the identified patient. For older adults, the focus shifts more toward chronic disease management, management of known mental health conditions, and substance abuse. However, the



whole continuum of care from prevention and health promotion to early identification and intervention, and to chronic condition management applies across all ages.

It is important for each practice to become familiar with the models of integrated behavioral health care, be able to identify their current stage along the continuum of integrated care and develop plans to move along the continuum toward truly integrated care. The building blocks outline key activities and skills needed to develop integrated care in the context of health care reform. The intent of SIM is to support practices in developing the skills of an advanced primary care practice (as formulated through the 10 building blocks) and to use those skills to improve patient outcomes, practice productivity, and the integration of behavioral health. While the SIM initiative will track progress on all milestone activities, not all practices will have the time, capacity, or financing to complete all activities. Practices are encouraged to focus on those activities most likely to provide sustainable impact for their patients and care teams and practice efforts should align with practice priorities.

SIM will provide several types of technical assistance to participating practices to support them in these activities. The core components of this support include coaching by a Practice Facilitator (PF) and a Clinical Health Information Technology Advisor (CHITA), support from a Regional Health Connector (RHC), semi-annual peer Collaborative Learning Sessions, webinars and other training opportunities, and the ability to apply for funding for innovative projects that advance the goals of The Colorado Framework.

The goal of this technical assistance is to grow a rich, statewide learning network composed of patients, practices, facilitators, project staff, state agencies, and national experts working towards improving the health of Colorado communities. Diversity in people, clinics, and approaches is valued. A wide array of practice types will participate in SIM, including family practices, pediatric practices, internal medicine practices, school-based health centers, residency training programs, large healthcare systems, small private practices, rural and urban settings, mental health centers taking on the primary care role for people with serious mental illness or children with serious emotional disturbance, and practices focusing on older adults with chronic disease. Rarely will a single solution apply to achieving the goals of SIM in all settings. SIM's learning network will flex to support innovative approaches to accomplish its overarching goal of achieving the Triple Aim across settings.

## **Practice Milestone Activities**

This section of the SIM Implementation Guide details the milestone activities associated with each of the “10 building block” concepts, with a section devoted to each building block. Each section outlines the intent of the building block, important definitions, the work for the medical home described as “Activities” and “Steps”, and suggested “Action Items” to get practices started. Appendix A summarizes the SIM Practice Milestones Activities. As you read through each of these Building Blocks and the specific associated Milestone Activities, it may be helpful to print Appendix A and use it as a reference.

### **Building Block 1: Engaged Leadership**

#### **Overview**

In order to successfully drive improvement in quality and patient outcomes, it is critical that leaders have the ability to lead through challenges and change with innovative ideas, approaches, and the ability to engage and motivate others. This is known as “innovation leadership,” an approach that challenges assumptions, coordinates, integrates and facilitates clinical processes, and builds support to align and link processes throughout the practice.

Keeping the concept of innovation leadership at the center, the team of engaged leaders within SIM practices must complete a series of steps to establish a strong foundation upon which the practice can rely as it proceeds through the process of practice transformation. These steps are outlined below, along with guidance on how SIM practices can best achieve and maintain identified concepts.

#### **Activity A**

**Step 1: Practice completes all SIM practice and practice member assessments based on SIM Office timelines.**

#### **Action Items**

1. In order to achieve Step 1 of Activity A, it is essential that the SIM practice has a SIM Implementation or Quality Improvement (QI) Team in place. While these terms are meant to be used interchangeably, for the purpose of this guide, the term QI Team will be used. If a QI Team does not currently exist, please reference the SIM Toolkit resource “[Getting Started with QI Module](#)”, developed by Rocky Mountain Health Plans.

The key changes that will occur upon the creation of a QI Team are:

- The formation of a QI Team with identified key staff member from each area of the practice.

- The identification of a practice champion.
  - The definition of responsibilities of each team member.
  - The scheduling of regular team meetings focusing on QI projects, in this case SIM, within the practice.
2. With a QI Team in place, the next step is to utilize practice assessment tools to assist the practice in determining their starting point and prioritizing processes for QI work. Assessment tools for SIM include the following:
- a. Practice Application (completed for practice selection)
  - b. Additional practice demographics (completed at baseline)
  - c. Medical Home Practice Monitor (completed every 6 months)
  - d. IPAT (completed annually)
  - e. Clinician and Staff Experience Survey (completed annually)
  - f. Milestone Activity Inventory (updated every 6 months)
  - g. Data Quality Assessment (updated every 6 months)
  - h. Practice Improvement Plan (updated every 6 months)

The purpose of each of these assessment tools and additional details on their use can be found in Appendix B and ultimately on the SIM Shared Practice Learning and Improvement Tool (SPLIT). The SPLIT is under development and will be referenced throughout this version of the Implementation Guide as the repository for assessments and reporting and as a placeholder for this resource. Further details, access and training for both Practice Transformation Organizations and practices related to SPLIT will be available in February 2016.

## Activity B

**Step 1: Primary care practice champions receive training on continuum of behavioral health (BH) services and advanced BH integration strategies. SIM bidirectional health home champions receive training on continuum of primary care strategies.**

SIM promotes a broad definition of behavioral health (BH) that encompasses mental health concerns, substance abuse conditions, health behavior change, life stresses and crises, and stress-related physical symptoms. For children, adolescents and young adults, BH includes preventive education/counseling, BH screening and early BH intervention incorporated into the primary care setting. Behavioral health integration (BHI) refers to “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.” BHI can take on many forms—coordinated, co-located, and integrated. SIM does not require all practices adopt fully integrated models of BHI. Each practice must determine what form is best for them.

SIM also will support a number of community mental health centers in implementing a bidirectional health home model. In this model, traditional mental health centers

integrate a primary care team within the mental health setting to address the primary care needs of their population. The bidirectional health home initiative seeks to deliver comprehensive, integrated care in the setting most logical and convenient to patients and their families.

### Action Items

1. Complete training on the continuum of BH services. Early training opportunities will include:
  - a. SIM eLearning module on Behavioral Health Integration
  - b. Collaborative Learning Sessions
  - c. Other resources included in the SIM Toolkit
2. Complete the practice assessment activities, particularly the Integrated Practice Assessment Tool (IPAT), to understand where your practice currently stands related to the levels of BHI and prioritize next steps in addressing your patients' BH needs. See Appendix B for the list of assessment activities.
3. Discuss which BHI strategies--coordinated, co-located, or integrated--will best address your patients' BH needs in a sustainable manner. Your Practice Facilitator, CHITA, and Regional Health Connector can help find resources for ongoing training and support for integrated teams.

### Activity C

**Step 1: Practice completes an annual budget or forecast with projected new SIM revenue flow and plan for anticipated practice expenses associated with practice redesign and integration activities.**

Perhaps the best indicator of future economic success is having and using a budget to plan and evaluate financial performance. However, many practice leaders don't fully realize the value of this management tool and fail to develop a budget or, even if their practice has a financial budget, they fail to take full advantage of the information it provides. Since a budget can be an important tool to ensure practice profitability, why don't more practices develop and use a budget? The answer is often simple. Many providers and business managers are unaware of the budget process and its benefits and don't take the time from day-to-day operations to create and use a budget.

The practice's budget serves as its annual financial plan as it defines the resources available to attain short-term and long-term goals and compares actual performance to what was forecast. Creating an annual budget is not difficult when you break down the process into its components:

- Step 1: Determine the expectation for compensation for the practice's physician owners/shareholders/partners.
- Step 2: Forecast the volume and types of services you will provide.
- Step 3: Estimate the revenue you will receive for the services.
- Step 4: Predict the operating expenses for the volume of services.

- Step 5: Based on the estimates for practice revenue and operating expenses determine if the physician compensation forecast is reasonable. If not, refine the three components of the budget to achieve a balanced solution.
- Step 6: Compare monthly financial statements and productivity reports to the budgeted values to determine why actual performance is different from what was forecast.
- Step 7: Revise the budget with updated financial and patient volume information to improve the forecast.

Will having a budget ensure financial success? By itself, it may not. However, a practice leader needs to plan and constantly evaluate how well a practice is performing and the budget provides the framework to do so. While it is possible to be profitable without planning, it is much more probable that an organization will be successful when it plans and employs good management techniques, and the budget is one of the most important tools in that process.

#### Action Items

1. Review the budget process by reading, “A Guide to Creating and Using a Budget” in the SIM Toolkit.
2. Use a budget template that accounts for compensation expectations, volume estimates, operating expenses, and revenues. If the practice does not have a budget template already, a template can be referenced in the SIM Toolkit.
3. Consider utilizing the Medical Group Management Association (MGMA) DataDive™, with its in-depth cost, staffing, productivity, and compensation benchmarking data and reporting and analysis tools. A license to these products will be provided to all SIM practices during their two-year participation in the project by MGMA. A description of the tool can be found in the SIM Toolkit.

#### **Activity D**

**Step 1: Fully engage and cooperate with ongoing evaluation and technical assistance deliverables as defined by SIM Office.**

#### Action Items

1. Complete the necessary practice agreement with the University of Colorado and choose a Practice Facilitator (PF) and Clinical Health Information Technology Advisor (CHITA).
2. Schedule a kick off meeting with your PF and CHITA to discuss the SIM initiative requirements and support opportunities.
3. Complete and review the results of your practice assessments with your PF and CHITA using them to identify gaps and prioritize next steps.

4. Set regularly scheduled meetings with your PF and CHITA to follow up on action items.

## **Building Block 2: Data Driven Improvement Using Computer-Based Technology**

### **Overview**

The intention of Building Block 2 is to help your practice take a systematic approach to using data from and about your practice to guide improvement in care. Reviewing data at both levels identifies areas for improvement, potential documentation areas, and best practice sharing. Data driven improvement builds key competencies in:

1. Advanced measurement and goal setting capabilities.
2. Improved data quality and data validation techniques.
3. Effective use of data and other quality improvement techniques/tools.
4. Optimized use of all available health information technology (HIT).

Data driven improvement is guided by collecting, reporting, and analyzing data to determine priority area(s) in your practice to focus improvement efforts. Using data allows the practice to assess priorities, identify where changes are needed and measure whether the identified changes are improving outcomes. Your practice will use data from your electronic health record (EHR) including demographics, disease registries, utilization indicators and prescriptions to guide improvement in at least three areas of care measured by the clinical quality measures (CQMs). It is best practice to post care team and practice level data in a centrally located place where all staff and even patients have access to view the data. This opens the door for conversation and accountability.

Additional data sources may include:

- Payer: cost/utilization reports, gaps in care reports, and attribution lists
- Health Information Exchange (HIE): utilization, labs, and imaging reports
- Patient and Family Survey/Advisory Council data
- Practice Operations: tracking no shows, cancellations, access, and hospital data on hospitalizations and Emergency Department utilization

These data will be utilized during regular QI Team meetings and will serve as a foundational component in selection of measures that best align to your patient population and transformation priorities. It is best practice to post care team and practice data in a central location where staff and even patients can view the data.

Appendix C provides a list of the CQMs and summary of the CQM reporting requirements.

### **Activity A**

**Step 1: Practice completes and submits a baseline assessment to determine data capacity.**

Action Items

1. Practice works with their CHITA to complete the Data Quality Assessment (DQA) on the SPLIT website at baseline and updates it every 6 months.
2. Use insights from the DQA to determine HIT priorities and set SMART (Specific, Measurable, Actionable, Realistic, and Timely) goals.
3. Identify and empower the proper care team members to work on HIT goals.

**Step 2: Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data, and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.**

Action Items

1. Work with your CHITA to identify current reports available from the EHR or other data sources.
2. Determines which data source(s) will provide the best data to guide improvement. Choose a small number (2-4) of those reports to start with that: are readily available, easily updated, align with clinic improvement priorities, can show change in 3-6 months, and measure processes or outcomes important to patient health and experience.
3. Identify a champion or champions to be responsible for the validation, production, review, and communication of the metrics.
4. Validate the data.
  - Spot check patients identified on the reports to make sure they match the target population and that their information is correct.
  - If errors are found, determine if it is a data entry error, process error or technology limitation/error.
5. Schedule time in regular practice or QI Team meetings to review the data as a group.
6. Identify or develop new measures to support new and changing practice priorities.

**Activity B**

**Step 1: Practice trains 50% of staff in improvement methods and tools and forms QI Team that meets regularly.**

### Action Items

1. Practice receives training on quality improvement methods and tools.
2. Practice receives training on how to form a QI Team.
3. Practice trains staff on quality improvement methods and tools.
4. Practice selects QI Team members.
5. Practice sets regular (1-2 meetings/per month) QI Team meeting schedule. It is recommended that practice QI Team meetings meet twice monthly.

**Step 2: Practice incorporates regular improvement methodology to execute change ideas in a rapid cycle. Document a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.**

### Action Items

1. Practice uses quality improvement tools and methods.  
Examples include: Process mapping, brainstorming, fishbone diagram, etc.
2. Practice develops and documents a [PDSA](#) for rapid cycle improvement.
3. Practice studies the changes implemented as part of the Study component of the PDSA to adjust the plan as needed and repeats the PDSA until it is a sustainable process.

## **Activity C**

**Step 1: Practices selects the CQM group that best aligns to their patient population and transformation priorities.**

### Action Items

1. Review the SIM Clinical Quality Measure (CQM) groups. See Appendix C.
2. Choose either the Pediatric or Adult/Family CQM group based on the patient population your practice serves.

**Step 2: Practice meets SIM Office CQM reporting requirements.**

SIM CQM reporting requirements are detailed in Appendix C. In general, SIM will use a rolling 3-month reporting period for their CQM's based on calendar quarters. Reporting of numerators and denominators for CQM's at a practice OR provider level will be expected within one month from the end of the calendar quarter. The first required reporting period is Quarter 2 of 2016 (ending June 30, 2016). Collection and performance reporting of CQMs will be managed through the SIM Quality Measure



Reporting Tool (QMRT). The QMRT is anticipated to be operational by mid-April 2016. Training on using the QMRT will be available after its development.

Detailed instructions for the Colorado SIM CQM's as well as tools to support the development, extraction, validation, reporting, and review of SIM CQM's will be posted on the University of Colorado Department of Family Medicine Practice Innovation Program's website, projected to go live in February 2016.

#### Action Items

1. Generate numerators and denominators for the CQMs within the chosen CQM group on a quarterly basis. Refer to Appendix C for the timeline of when certain core measures are due.
2. Work with the CHITA to validate the CQM reports.
3. Submit numerators and denominators to the QMRT within one month of the end of each calendar quarter.
4. Review QMRT Practice Performance Reports to track improvement over time.
5. Create a development plan for any CQMs currently not available to your practice, prioritizing the core SIM measures and CQMs related to your practice's QI activities.

#### **Step 3: Practice uses automated data extraction through HIE to supply data for SIM CQM reporting.**

More advanced, automated CQM reporting methods will be made available through SIM HIT activities. These methods are still under development, and details will be communicated to SIM practices as soon as they are available.

#### Action Items

1. Stay informed of the latest SIM HIT opportunities by meeting regularly with your CHITA, checking on the [Colorado SIM](#) and University of Colorado Department of Family Medicine Practice Innovation Program's website, and attending SIM Collaborative Learning Sessions.

#### **Activity D**

#### **Step 1: At least quarterly, use data hub benchmark reports to inform continuous quality improvement on at least three clinical quality measures (CQMs).**

#### Action Items

1. Identify a practice champion who will be familiar with the QMRT practice performance reporting tool.

2. Schedule time to review your practice's performance on CQMs and compare it to other SIM practices.

### **Building Block 3: Empanelment**

#### **Overview**

Empanelment identifies the patients and population for whom the provider and/or care team is responsible and creates continuity between patient and provider/care team. Many consider empanelment foundational to quality improvement and practice transformation work. Effective empanelment requires identification of the “active population” of the practice, meaning those patients who identify and use your practice as a source for primary care. There are many ways to define “active patients” operationally. Generally, the definition of “active patients” includes patients who have sought care within the last 24 to 36 months, allowing inclusion of some patients who have minimal preventive or chronic health care needs. Empanelment requires ongoing monitoring as patients change primary care providers (PCPs), move, or pass away as well as tracking when a provider leaves the practice. Empanelment improves patient and care team satisfaction, improves receipt of preventative services as well as reducing hospital admissions and emergency department (ED) visits. For community mental health centers working on integrating primary care, there may be separate panels for the PCP and the psychiatrist. For the purposes of SIM, the patient panel should be aligned with the PCP.

#### **Activity A**

**Step 1: Practice documents strategy to achieve and maintain empanelment to provider and care teams.**

##### **Action Items**

1. Review empanelment options with key providers and staff. See SIM Toolkit for empanelment resources.
2. Determine empanelment methodology and workflow and document agreed upon procedures.

**Step 2: Achieve and maintain 80% empanelment to provider and care teams.**

##### **Action Items**

1. Implement chosen empanelment strategy, assigning all active patients to a provider panel, confirming assignments with providers and patients, and planning for empanelment of new patients.
2. Assess practice supply and demand, and balance patient load accordingly.

3. Monitor extent of empanelment through EHR or other reports to determine percentage of patients empaneled.
4. Periodically update empanelment, rebalancing provider and care team panels and assigning un-empaneled patients to a provider and care team.
5. Review and adjust empanelment methodology based on practice needs and experience.

**Step 3: Achieve and maintain at least 95% empanelment to provider and care teams.**

Action Items

1. Practice runs reports regularly (i.e. quarterly) to determine empanelment status and works to maintain 95% empanelment to providers and care teams.
2. Review and adjust empanelment methodology based on practice needs and experience.

**Activity B**

**Step 1: Practice periodically reviews attribution lists provided by payer(s) to reconcile discrepancies.**

Action Items

1. Practice reviews payer(s) methodologies for distribution of attribution reports and their methodology for reconciling discrepancies.
2. Practice reviews within one week of receipt of attribution reports, lists of patients and compares against empanelment panels.
3. Practice actively follows payer(s) methodologies within one month of receipt of attribution lists to reconcile any discrepancies in patient lists.

**Step 2: Practice achieves 70% concordance between internally empaneled patients and payer attribution lists.**

Action Items

1. Practice reviews at least one payer attribution report and compares it to internal empaneled patients from that payer.
2. Practice works with payer(s) to reconcile discrepancies within one month of receipt of attribution lists and monitors concordance, targeting a goal of >70% concordance.
3. Expand efforts to include attribution reports from more payers.

## **Building Block 4: Team-Based Care**

### **Overview**

Team-based care is a necessity in the primary care setting. Without a team-based approach, clinicians spend valuable time providing care that could be done by well-trained non-clinicians. Estimates suggest that for a panel of 2,500 patients, a clinician would spend 17 to 18 hours per day providing the recommended preventive, chronic and acute care.<sup>3,4</sup> Teamwork in the primary care practice has been shown to improve both clinical quality and patient and provider experience. Team-based care has also been shown to lead to greater career satisfaction and less burnout of the staff in primary care practices.<sup>5-15</sup> By working together in a team, providers report that they have the time they need to listen, think deeply and develop relationships, while other team members are also more involved in direct patient care and, therefore, better able to answer patient questions and coordinate care.<sup>15</sup> As a result of teamwork, all members of the practice team are valued and feel engaged in their key role of patient care.

Building practice teams involves expanding roles of staff and care providers, providing training for those expanded roles, developing trust and teamwork, and utilizing standing orders so staff can act independently. Leadership and a commitment to change the traditional hierarchical model of care to a more team-based culture is crucial to building effective teams. Assessing your practice to highlight specific areas where your practice has room to improve is a good place to start when implementing team-based care.

### **Activity A**

**Step 1: Practice periodically (baseline and at least annually) reviews assessment of distribution of patient care tasks by role.**

#### **Action Items**

1. Complete a practice assessment of the distribution of patient care tasks by role to help sites measure how practice teams are functioning. The “[Assessments for the Practice Team](#)”, developed by the [MacColl Center for Health Care Innovation](#), can help sites pinpoint areas of strength and areas needing improvement. Additional resources available in the SIM Toolkit.

**Step 2: Practice better distributes workload throughout the team in ways that makes optimal use of team members' training and skill sets.**

#### **Action Items**

1. Build a culture that supports teamwork that will empower staff to take on new roles, act independently, and communicate effectively.
  - a. Identify the leaders of each practice team.

- b. Establish and provide organizational support for the teams including protected time for teams to interact and plan their activities.
  - c. Review the toolkit for resources.
2. Develop clear roles and responsibilities for each team member. Distribute the workload throughout the team to make optimal use of each member's training and skill set. Develop training for team members on new skills.
3. Encourage and support staff to work independently to perform patient care tasks.
  - a. Standing orders enable staff to independently and efficiently perform key clinical tasks without having to involve the provider.
  - b. Identify leadership who will help to create standard workflows for the delivery of common services.
  - c. Incorporate standardized protocols for care and treatment of patients into practice workflows and into the EHR.
4. Help patients understand what they can expect from the team-based care model through pamphlets, phone scripts, in-person conversations, and other means of communication.

## Activity B

**Step 1: Practice implements at least one of the following team-based care strategies:**

- Daily team huddles to plan for patient visits
- Collaborative care planning sessions
- Standing orders

**Step 2: Practice implements at least two of the activities listed above.**

### Action Items- Daily Team Huddles

1. Create a template agenda for daily huddles that includes the topics that will be discussed each day. Huddles typically help:
  - a. Prospectively plan for patients who can benefit from pre-visit activities (i.e. point of care tests, immunizations, paperwork) and extra time and assistance.
  - b. Communicate and prepare for staff, provider or equipment changes.
2. Regularly adjust huddle timing, participants, and agenda to best align the team at the start of a clinic session, build team culture, and improve communication for a more engaged workforce.
3. Resources to assist practices in organizing their huddles can be found in the SIM Toolkit.

### Action Items- Collaborative Care Planning Sessions

Collaborative care planning sessions are practice team meetings that help plan for care of an individual patient or panel of patients. Professionals on staff, including but not limited to behavioral health, pharmacy and care management who share in the care of patients can approach challenges and strategies to better meet the needs of complex patients. This is also a time when these multi-disciplinary professionals can communicate directly with one another to address concerns and plan appropriate patient follow up.

1. Implement a regularly scheduled collaborative care planning session with the practice team to discuss the overall care of selected population of empaneled patients.
2. Practice team members can include, but are not limited to, providers, patients and families, nurses, medical assistants, care coordinators, behavioral health specialists, and clinical pharmacists, and psychiatrists.
3. Adopt consistent strategy and expectations for conducting care planning sessions that will keep the team efficiently moving through the review of multiple patients. Examples may include an agenda or a shared template for preparation and review.
4. Set aside pre-planned, regular times to conduct care planning sessions with the team.

### Action Items- Standing Orders

Standing orders are protocol-based workflows that care team members can follow based on a common, easily identified patient characteristics such as a symptom, diagnosis, or visit type without the need for providers to initiate the services each time. Standing orders allow patient care to be shared among members of the care team and all members of the care team to function to their fullest capacity.

1. Work with the clinical leadership team to decide which symptoms, diagnoses, or visit types would qualify for a clinical protocol. Some common standing orders include:
  - a. Symptoms triggering point of care testing for urinary tract infections, pregnancy, influenza, or and strep throat.
  - b. Well child and annual visits prompting appropriate immunization administration, screening protocols, and preventive services referrals.
  - c. Diseases such as diabetes triggering recommended periodic services like monofilament exams, A1C testing, and eye exam referrals.
2. Develop a written protocol that explains qualifying patient conditions or developmental needs, staff responsibilities, required documentation, billing procedures, and clinical oversight. Practices may base protocols on national clinical guidelines, adapting them to their own patient population and care team resources.

3. Increase buy-in by reviewing individual protocols with providers and staff. Empower staff to seek help when a symptom, diagnosis, or situation does not fit within the standard protocol.
4. Train staff members how to use the standing order protocols. Include time to supervise staff new to the protocol to ensure proper implementation.
5. Review and update standing orders and protocols on a regular basis and be sure to re-train and update providers and staff with the new information.
6. Resources can be found in the SIM Toolkit.

## Activity C

### **Step 1: Demonstrate that individualized patient treatment plans that include both physical and behavioral health goals of care are accessible in the practice's EHR.**

Individualized patient treatment plans, also known as “shared care plans” or, simply, “care plans”, improve efficiency and promote timely, patient-centered care. To be comprehensive, care plans should incorporate both physical and behavioral health goals and reflect the goals of providers, patients, and their families. To support collaborative and continuous care the documents should be easily available in the EHR for all practice team providers to access. If the practice is working with an integration partner, this may require the electronic exchange of information such as through continuity of care documents (CCDs).

#### Action Items

1. Identify important pieces of information that should be included in an individualized patient treatment plan, including physical and behavioral health goals. Create a template with appropriate headers or instructions for people to follow. Keep in mind care plans need to allow for a variety of types of patient goals, and components of the plans may be different for different populations (i.e. adults vs. children, patients seeing multiple specialists vs. healthy individuals).
2. Train all care team members to create, access, and update care plans.
3. Set an initial goal for the number of care plans to be created within a certain amount of time. Consider starting with a subset of the practice's empaneled patients to allow care teams to practice and provide feedback on the process.
4. Decide where in the EHR the individualized care plan will be documented.
5. Develop a process to update the care plans regularly to keep all team members up to date.

6. Consider how individualized care plans could be shared, with proper permissions, across medical specialties within the medical neighborhood.

## **Activity D**

**Step 1: Participate in SIM Collaborative Learning Sessions held twice a year. Serve as peer presenter at the Collaborative Learning Sessions when requested.**

Often the best solutions come from practices that have tested and implemented innovative ideas. SIM will host Collaborative Learning Sessions twice a year for SIM practices to share their successful ideas and learn from one another. New knowledge can be shared between practices that are actively engaged in advanced primary care approaches like integration of behavioral health, community engagement activities, and adopting value-based payment strategies. Discussing how different tools and workflows can be incorporated into everyday practice can provide valuable and efficient shortcuts in executing changes. Interaction with other practices helps to provide energy, ideas, and support for change.

### Action Items

1. Send at least two care team members, typically a provider champion and staff champion, to each SIM Collaborative Learning Session.
2. Encourage other team members that they feel will benefit from the supportive learning environment to attend the Collaborative Learning Sessions.
3. Shape the SIM Collaborative Learning Session agenda by suggesting topics you would like addressed, or innovative ideas you would like to share on a panel or in a breakout presentation.

## **Building Block 5: Patient Team Partnership**

### **Overview**

Advanced primary care practices provide care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient and family's unique needs, culture, values, and preferences. The advanced primary care practice actively supports patients and families in learning to manage and organize their own care at the level the patient chooses. These practices ensure that patients and families are core members of the care team and fully informed partners in their own care.

One of the ways that patients and families become a full partner in care is through shared decision-making (SDM) about health care. SDM is a process that occurs between the members of a practice and the patients and families. It is demonstrated by collaborative decisions about prevention, treatment, and advanced treatment-planning for the patient and family. It means that the provider is responsible for sharing the latest evidence to inform the care plan, but the plan also takes into account, the



person/family's culture, values, and opinions. SDM ensures that the person/family are fully informed about treatment and the risks/benefits of treatment and not doing treatment, and supports individualized care decisions.

For patients and families to feel like a full partner, they must have an understanding of how to prevent illness, promote health and well-being, manage healthy lifestyles, and manage chronic illness conditions. Each practice will look at how they can assist patients and families toward gaining independence and self-management of specified high risk conditions.

To be a true partner, the practice must gain an understanding of the patient's and family's perspective on the care experience. Advanced practices have patients help shape operations by soliciting and acting on feedback from surveys and engaging patients and families in advisory roles to set and address clinic improvement priorities. Gathering this feedback and establishing ways to communicate information back to the patients and families are goals of Building Block 5.

## Activity A

**Step 1: Implement self-management support for at least three high risk conditions.**

### Action Items

1. Familiarize care team members with the concepts of self-management support. Resources can be found in the SIM Toolkit.
2. Choose three high risk conditions that could be improved by providing self-management support resources. Conditions could include physical health or behavioral health concerns that result in high utilization, high cost, and/or lower satisfaction rates or socio-demographic risk factors that contribute to poor utilization of preventative health services. *Examples could include:* obesity in children or adults; diabetes in adults; depression care in children, adolescents, and/or adults (e.g., pregnancy-related depression); prematurity or other special health care need in infants; asthma care for children, adolescents, and/or adults; misuse of alcohol or marijuana.
3. Once high risk conditions are identified, select appropriate self-management tools and make these tools available to patients. For pediatric populations, self-management tools may target the parents or primary caregivers in addition to the child, if developmentally appropriate.
4. Use patient input on the tools to make them optimally appropriate for your patient population.
5. Monitor patient satisfaction with self-management tools and adjust approaches to increase impact of these tools on patient outcomes.

## Activity B

**Step 1: Implement shared decision making tools or aids for two health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in CMHC must be related to physical health.**

**Step 2: Track use of shared decision making aids using one of the following methods:**

- A metric tracking the proportion of patients and families eligible for the decision aid who receive the decision aid; OR
- Quarterly counts of patients and families receiving individual aids.

#### Action Items

1. Identify tools to facilitate shared decision making for two conditions, decisions or tests. Examples include:
  - a. Asthma action plans that define green, yellow, and red indicators of asthma control and what to do for each level.
  - b. Decision aids for cholesterol management such as Mayo Clinic’s online aid for shared decision-making for cardiovascular prevention, medication options for depression (see the SIM Toolkit).
2. Train appropriate care team members and providers on when and how to use the tools.
3. Create processes and assign responsibility for care team members to track the use and impact of shared decision making tools. These processes should clearly identify outcome and process indicators of change in practice and patient outcomes, specify when and how the data will be collected, analyzed and communicated to the practice.

#### **Activity C**

**Step 1: Assess and improve patient and family experience of care by selecting at least one of the following.**

- Regular patient and family surveys at least quarterly.
- Patient and family advisory council that meets at least quarterly.

#### Action Items – Patient and Family Surveys

1. Select a survey or modify/adapt an existing survey to meet practice needs. Consider including questions that can directly inform tangible improvement activities.
2. Develop an implementation plan that allows for patient and family experience data collection on at least a quarterly basis and more frequently (e.g., after each visit) if possible.

3. Determine roles and responsibilities related to gathering, inputting, aggregating, reviewing, and disseminating survey results.
4. Determine protocols to respond to dissatisfied consumers and to concerning information that is revealed in the course of data collection.
5. Identify how information is shared with care team members in the practice and how it is used to inform practice change.
6. Periodically adjust the survey questions and implementation plan to improve patient and family experience more effectively.

#### Action Items – Patient and Family Advisory Council

1. Identify one or two practice champions to co-facilitate the Patient and Family Advisory Council.
2. Develop a recruitment plan (number of members, representative of practice population, supports/incentives for participation, length of service).
3. Recruit participants and secure commitments for engagement.
4. Set meeting dates/locations in advance and on a quarterly basis. Adjust times, services, and locations to maximize participation from target patient advisors. For example, working adults may need to meet outside of normal business hours, and parents may be more engaged if they can bring their children and have on-site childcare. Snacks or meals should be offered depending on the timing of meetings.
5. At the first meeting, determine governance structure including how agendas will be set, how feedback will be gathered and shared, and sphere of influence of the Patient and Family Advisory Council.
6. Periodically review the advisory council and adjust membership and processes to address patient experience more effectively. Particularly in the beginning, obtaining feedback from participants and making the necessary adjustments will increase the success and longevity of the council.
7. The [Patient and Family Advisory Council produced a step-by-step guide](#) for creating a patient and family council.

**Step 2: Develop communication(s) to patients, families, and the clinic about the specific changes the practice is implementing (e.g. a pamphlet or posters displayed in clinic, website updates, or newsletter/email/text messaging), including the efforts related to integrated care as a result of, or influenced by, practice survey/PFAC activities.**

## Action Items

1. Identify how information about patient engagement, self-management, and shared decision making is communicated with all patients and families.
2. Identify how to communicate, either by poster or audiovisual display or by electronic means, what the practice is doing based on patient and family feedback.
  - a. If the practice will use a pamphlet or poster, use health literacy tools to engage patients and family and keep the message geared to the population (English, Spanish, lower literacy, etc.).
  - b. Practice to identify reporting mechanism that captures successes and features changes as a result of patient and family feedback (e.g., “you told us and we listened” type messages).

## Building Block 6: Population Management

### **Overview**

Population management is a core activity of advanced primary care practices. It requires care teams to take responsibility for a defined group of people (often their patient panel) and develop interventions to improve health outcomes for the entire group. Efficient practices identify sub-groups of their patients that will benefit from similar interventions like patients with a particular diagnosis (e.g. asthma or diabetes) or risk factors (e.g. psychosocial, environmental, and familial adversity factors) and then tailor systems of care to those groups that result in measurable health improvements.

For many factors affecting health, elements of community are important. If a patient panel is to show improvement in outcomes such as tobacco cessation, weight control, physical activity, or mental health, community resources affecting those issues will be as important as the clinical factors. Because many of the concepts and skills needed to improve the health of a patient panel are the same as those needed to improve the health of the broader community, effectively measuring health and improving outcomes for a patient panel will translate into a practice’s ability to also influence the health of the broader community.

The goal of this building block is to help practices successfully create and implement processes that improve the health of groups of people with particular chronic conditions and/or particular risk factors for disease. These evidence-based strategies include screening for behavioral health and psychosocial conditions, using registries, risk stratification, and care management for high risk patients and families.

Risk stratification is the process of assigning a category of risk for each patient in a practice in order to create subgroups of patients for whom more attention will improve outcomes. Establishing a risk stratification strategy in a practice requires an objective

look at the practice's panel, evaluating predetermined factors. In general, there are three overarching methods to assign risk to patients:

- **Care Team Judgment:** Providers and other care team members assign a risk category to individuals based on their knowledge of the patient in comparison to other patients in the practice panel.
- **Algorithms:** Each patient is given a risk score based on a predetermined equation that can combine multiple factors such as demographics, diagnoses, prescription medications, utilization, cost, biometrics, or social determinants. These can be automatically generated or done by hand. Several validated algorithms are available.
- **Thresholds:** Patients are determined to be in a high risk group once they meet certain conditions. Examples of a common threshold category involve high cost utilization like patients with 4+ ER visits in a year or anyone with a 30 day readmissions in the last 6 months, but thresholds can involve any type of patient factor.

Some practices may choose to combine aspects of one or more method. It will be up to each practice to work with their Practice Facilitator to implement the method or methods that best fit their local needs and resources.

## Activity A

**Step 1: Indicate methodology used to assign risk status to every empaneled patient.**

**Step 2: Establish and track metrics for percent assignment of risk status and proportion of population in each risk category.**

**Step 3: Continue to risk stratify all patients, achieving risk stratification of at least 75% of empaneled patients.**

### Action Items

1. Review available risk stratification methods with your QI Team and care teams. Keep in mind the time and personnel costs needed to develop each method and how your practice would use the information to improve care processes for high risk patients and their families. Your Practice Facilitator or CHITA can be helpful in identifying resources and information on various choices. See the SIM Toolkit risk stratification resources.
2. Decide on a risk stratification method.
3. Assign and empower at least one practice champion to coordinate the development, validation, training, communication, documentation, and monitoring aspects of the risk stratification method.

4. Schedule time to review the process, track the proportion of the clinic's patients in each category, adjust implementation plans, and link the risk categories to care management strategies in the clinic.

## **Activity B**

This activity builds of the risk stratification activities described above. Once high risk patients are identified the next step is to tailor care management interventions to improve outcomes for the highest risk patients and, when appropriate, their families.

### **Step 1: Provide care management to at least 80% of highest risk patients.**

#### Action Items

1. Define a business case for the care management program that includes financial supports and sustainability plan.
2. Determine outcomes for success.
3. Identify and stratify patients (see above).
4. Develop a model of care delivery that includes roles of a care manager (if available) and rest of care team.
5. Consider and include external resources or sources of care that can extend the number of services available for patients.
6. Structure care management services and organize roles and responsibilities of the care manager and other care team members.
7. Enroll patients and provide services.
8. Learn, adapt, and grow.

### **Step 2: Implement two or more of the following three specific care management strategies for patients in higher risk cohorts (beginning with those at highest risk):**

- Coordination of behavioral health services obtained outside of practice (required for primary care).
- Self-management support (SMS) for at least 3 high risk conditions, including one behavioral health condition.
- Medication management and review.

#### Action Items – Coordination of behavioral health services obtained outside of practice (required)

1. Maintain a resource file for behavioral health services in the community and region that can be used by patients.

2. Assign someone in the practice to keep this resource up to date.
3. Determine how referrals are made and which patients are referred.
4. Determine where charting is done and what and who charts the patient and family information.
5. Define role of the Care Manager/Coordinator.
6. Create protocol to define how to access Behavioral health and community supports.
7. Determine who is responsible for maintaining a list of community resources that relate to the patient population served.
8. Determine who, how, and what collects, enters maintains and reports data.
9. Determine how care planning is done in the practice for physical medicine and behavioral health.
10. Define how the referral follow up system will work within the practice and what the acceptable standards are for follow up. How do providers know the outcomes of referrals to behavioral health services obtained external to the practice? How is ongoing treatment/engagement with behavioral health services tracked and documented?
11. Develop QI system for monitoring the above guidelines to ensure practice is achieving the desired results.

Action Item – Self-Management Support (SMS) for at least 3 high risk conditions, including one behavioral health condition

See Building Block 5: Patient Team Partnership, particularly Activity A, Step 1, for information on implementing SMS in your practice.

Action Items – Medication Management and Review

1. Assign duties within the practice for reviewing medications at each visit.
2. Ascertain patient self-reports of medication compliance at each visit, including issues of side effects, forgotten doses, and financial costs.
3. For patients with low compliance, pill counts can be selectively used for critical meds.
4. With patient consent, engage family members and caregivers in medication compliance discussions.

**Step 3: 80% of highest risk patients receiving care management services have an individualized patient treatment plan that includes both physical and behavioral health goals of care are accessible in the practice's HER.**

#### Action Item

See Building Block 4: Team-Based Care, particularly Activity C, Step 1, for information on implementing individualized patient treatment plans in your practice.

### **Activity C**

**Step 1: In primary care, attest that 90% of patients are screened for at least one behavioral health condition for which the practice has a documented workflow to assist patients who screen positive.**

#### Action Items

1. Work with the care team and QI Team to choose age and developmentally-appropriate screening tools for behavioral health conditions. Conditions for which evidence-based screening tools available include childhood developmental delays, autism, obesity in children and adults, depression in adolescents and adults, postpartum depression, anxiety, psychosocial and environmental adversity, and substance dependency. Resources for many screening tools can be found in the SIM Toolkit.
2. Develop protocols, documentation standards, monitoring reports, and trainings for how to use and interpret the screening tools, what to do when screenings are positive, and how to manage referrals and follow-up.
3. Regularly monitor the use of the tools to track the number of patients being screened. Explore if your EHR's also is capable of tracking appropriate follow up of positive screening tests and patient outcomes over time.
4. If <90% of patients receive a behavioral health screening test, consider adjusting current workflows or implementing additional screening tools.

### **Step 2: Measure and report reach of behavioral health (BH) screening and treatment activities.**

Reach is one way to measure the impact of an intervention. It looks at the number and proportion of patients who are eligible for a given intervention that properly receive the intervention.

One example would be a practice that wants to start screening adolescent and adult patients for depression using a combination of an age appropriate PHQ-2 for all patients followed by an age appropriate PHQ-9 if the first screen is positive. The practice sees 100 qualifying patients on the first day of the intervention, and 70 of the patients finished the appropriate screening questions.



In this scenario, the depression screening intervention “reached” 70 patients or 70% of the potential population with the screening. Further tracking the percentage of patients receiving and then completing treatment can give reach calculations for those treatment steps.

Keeping track of reach across all BH screening and treatments allow practices to see if their efforts to expand BH services are impacting a larger number and percentage of their patient panels. In addition, it is critical to match the anticipated number of patients to be reached through screening activities to the capacity of services that can be provided to patients through the available resources.

#### Action Items

1. Start by listing the discrete behavioral health screenings and treatments provided in the practice along with the descriptions of patients who qualify for the interventions.
2. Develop a process for measuring how many qualifying patients are seen in a month and how many receive the intervention(s). If your practice has multiple BH interventions, consider tracking just one or two of the most important ones initially.
3. Review the reach of the BH interventions regularly. Adjust workflows or add BH screening or treatments to improve the reach of BH interventions in the practice. Consider examining caseload and productivity expectations to ensure that BH clinicians are able to deliver the services to the population of interest.

#### **Activity D**

Registries are needed to track the population groups targeted for services, referrals and risk stratification. Registries ensure that planned, recommended activities happen within acceptable time limits and that patients get the services they need and show improvement for identified care plan needs. Registries can be condition specific (e.g. asthma) or span a broader subpopulation of the clinic (e.g. wellness registry).

**Step 1: Practice uses a registry system to track outcomes of at least two subpopulations of patients. One system must focus on a behavioral health condition (e.g. depression, ADHD) and the other system may focus on another behavioral health condition, preventive health needs (e.g. well child checks, age appropriate screenings), or a chronic medical condition (e.g. diabetes, asthma).**

#### Action Items

1. Engage the QI Team to identify priority conditions to be tracked. Consider reviewing the registries and QI activities in place in the practice to align SIM and other ongoing improvement efforts.
2. When making a new registry consider:

- a. The source of the data (EHR, claims, other population health registry).
  - b. Patient diagnostic criteria (e.g. all depression or only depression on medications).
  - c. The outcomes to be assessed. Those can be process outcomes (compliance with treatments, appointments), as well as health outcomes (improved objective measures).
3. Establish the timeline of the work, including when the patient cohort will be defined, who will do the data analysis, and when the outcomes will be assessed.

**Step 2: Practice uses the two registry systems to identify and proactively outreach to patients with gaps in care and/or not achieving guideline-based treatment goals.**

#### Action Items

1. Assess outcomes from the registries on a regular basis (monthly preferred, but quarterly minimally).
2. Contact patients who are falling through cracks or who are not achieving pre-specified outcomes.
3. Engage care team members such as care managers, front desk staff, and others in patient follow-up as needed.

**Step 3: Practice is able to show sustained improvement in the care of the two subpopulations.**

#### Action Items

1. Build on previous work to assess outcomes from the registries and adjust clinical workflows and patient outreach efforts to show improvement in process and patient centered outcomes.
2. Once improvements are sustained consider focusing on new outcomes and/or new registry populations.

### **Building Block 7: Continuity of Care**

#### **Overview**

Continuity of care is the degree to which patients experience separate components of healthcare as coherent, organized, connected, and consistent with their needs. In the primary care setting continuity is often measured as the percentage of visits patients make with their own primary care provider when receiving primary care.

Continuity of care over time building long-term relationships between patients and providers. Strong patient-provider relationships foster improved communication, trust, and knowledge of patient context and preference. Not only does a strong patient-provider relationship lead to improved patient satisfaction but can lead to improved health behaviors, better health outcomes, and less emergency department and hospital use.<sup>16-19</sup>

Providers prefer strong, long-term relationships with patients as these relationships give their work more meaning.<sup>20</sup>

## Activity A

### Step 1: Track continuity with primary care provider and/or care team.

#### Action Items

1. Work with your Practice Facilitator to decide on a method for measuring continuity of empaneled patients with their assigned primary care provider and/or care team. Examples and instructions for continuity measures can be found in the SIM Toolkit.
2. Consider following the steps for this common method of calculating continuity in primary care settings:
  - a. Numerator: By reviewing the appointment schedule, obtain the number of patients of Provider X that were seen by Provider X in the past month.
  - b. Denominator: Also by reviewing the appointment schedule, obtain the total number of patients of Provider X that were seen over the past month. Make sure to stay within a time frame over which Provider X has influence, for example only patients seen 8:00 AM - 5:00 PM, Monday through Friday.
  - c. Divide the numerator by the denominator and multiply the results by 100. This will give you a percentage of continuity for Provider X.
  - d. Repeat process for all providers.
3. Regularly repeat continuity tracking and review the results and how they change over time with your QI Team.
4. Adjust scheduling, empanelment, patient communications, and other clinic workflows to improve continuity rates to a goal of >75%.
5. Develop strategies and tools for informing patients and families about the importance of continuity of care (e.g., reminders to schedule next appointments with your doctor; protocols for scheduling appointments with the same provider over time; appointment reminders with provider names and pictures, etc.) and encourage participation in selecting and scheduling with a continuity provider.

## Building Block 8: Prompt Access to Care

### Overview

Providing timely access to care is a core attribute of primary care and a key driver of patient satisfaction. A lack of access can cause patients to seek care in emergency rooms or urgent care centers or not receive needed care in a timely basis, leading to

increased expenses and poorer health. Effective access is important day or night, as is provider access to patient information at all times. This access promotes continuity of care by enhancing communication and promoting integration between services. Many strategies like regular monitoring and control of panel size can help lead to improved access.

The definition of access extends beyond “open appointments” to include access to “my provider” when necessary. Access to “my provider” is core component of continuity, but should be balanced with the patient-centered approach of allowing patients and their families to choose between waiting to see their provider or seeing an available provider sooner. High-performing practices assist patients in deciding which type of access is the priority.

New technologies like electronic patient portals offer advanced options for patients and their families to access health records and interact with their care team. These options can facilitate communicating to patients from the practice, receiving information electronically from patients (e.g., updates on well-being/symptoms; requests for appointments and medication refills), efficiently sharing changes in practice policies, and providing forms to patients/families to complete prior to or in between appointments.

### **Activity A**

**Step 1: Provide and attest to 24 hour, 7 days a week patient access to a practice representative that has access to practice’s medical record for patient advice and to inform care by other professionals, including behavioral health records if a behavioral professional is fully integrated in practice.**

#### Action Items

1. Work with your QI Team to develop a written protocol for providing patient access to their health records that includes procedures for record sharing, reporting, documentation, scheduling.
2. Regularly share information with patients (verbally and in writing) about accessing after-hours services, particularly when they are new to the practice.
3. Information about accessing after-hours services should be posted at the practice, detailed on websites, and provided in initial patient paperwork.
4. Regularly review policies and procedures for contacting the practice when the practice is closed, including setting expectations about who will be responding to calls (i.e. a nurse triage line, an on-call provider who is not part of the practice, the patient’s primary care provider, etc.). Be sure to include a process/procedures for responding to behavioral health urgent and emergent situations.

5. Consider developing processes for secondary triage to on-call response systems, access to clinical information, and next day scheduling systems.

## **Activity B**

**Step 1: Enhance access by implementing at least one asynchronous form of communication (e.g. patient portal, email, text messaging) and make a commitment for a timely response.**

### Action Items

1. Review options for HIPAA-compliant asynchronous communications with patients and choose a modality that best fits the practice's needs and budget.
2. Create protocols and practice standards for using the new technology including response times, appropriate delegation of tasks to care team members, handling overdue communications, and covering for team members when they are out of clinic.
3. Train providers, staff, and patients and their families how to use the technology.
4. Monitor implementation (e.g., number and type of communications, level of documentation of calls, and patient satisfaction) and adjust protocols to improve the effectiveness of the tool.

## **Building Block 9: Comprehensiveness and Care Coordination**

### **Overview**

Together, comprehensiveness and care coordination form the ability of the primary care team to meet all of the needs of the client and their family. The milestone activities in this building block focus on care coordination to strengthen the connection between a primary care practice and its surrounding community resources, including behavioral health and medical specialty providers. Activities help practices to “close the loop” by identifying where patients and their families receive services outside the clinic and establishing workflows to follow up with clients and families.

Care coordination works best when primary care and external care providers work in tandem. Care compacts are collaborative agreements that facilitate this work and create systems to close the loop. They can include a variety of topics, including how quickly a patient should get an appointment, information that needs to be shared prior to the appointment, the time frame for a report from the specialist to reach the primary care provider, or an agreement of who is managing the ongoing care of the patient. Beyond specialty medical and behavioral health providers, care compacts also are used to streamline relationships with community groups such as schools, fitness centers, or organizations providing care management and social work services.

Completion of care compacts help primary care practices form a medical neighborhood, and help ensure consistency and reliability for patients through the relationships between primary care, behavioral health, medical specialty care, and community resources.

For children and their families, the agreements vary slightly. Most children need specialized services and equipment that reflect the changing size and developmental needs of a growing child. These services and equipment can be found in centralized facilities such as hospitals with both in- and outpatient care. Care compacts can be used for outpatient services and with specialists, but may be more difficult to negotiate with large institutions, like hospital systems. Community resources, such as food banks, transportation resources, and schools on the other hand, can often times be more easily navigated for successful care compacts.

It is important to emphasize that community mental health centers (CMHCs) will need the same relationship that is established through care compacts as primary care medical providers. CMHCs will need to develop relationships with medical specialists and their own community groups. If the CMHC is not also a substance use disorder treatment provider, relationships with appropriate organizations will be required. Children and their families will benefit from relationships with pediatric specialists, community resources, and schools.

## Activity A

**Step 1: Detail where patients access BH services outside of primary care practice. For SIM bidirectional health homes, detail where patients access primary care services outside of the health home.**

### Action Items

1. Compile a resource list or spreadsheet of behavioral health providers approved or in network for the commercial and public plans involved in the SIM initiative. Prioritize behavioral health centers and providers that accept the common payers seen in your practice and those locations open to new patients. Identify behavioral health providers that specialize in working with certain populations (e.g., pediatrics, families, early childhood, substance abuse and dependence, etc.) and denote specializations in the resource lists.
  - a. This list should include names, phone numbers, addresses and other information deemed important to providers and patients. Information may include hours of operation, procedures for obtaining initial appointments, necessary paperwork, etc. Preliminary lists may be found on company websites and may be added to using experience and word of mouth.
  - b. For Behavioral Health Providers under Medicaid, a list of Community Mental Health Centers (CMHCs) can be found by contacting the Medicaid office, or by performing searches by county.

2. Review and update this list regularly to ensure accuracy. It is often helpful to contact behavioral health providers with patients and families present, particularly when scheduling initial appointments.
3. Similarly, Community Mental Health Centers should develop a list for primary care providers approved or in network for the commercial and public plans. Beyond providing lists, behavioral health providers and agencies should provide primary care settings with information sheets and other materials/paperwork that will facilitate and streamline referrals. CMHCs should also create a system to review and update this list regularly. In Medicaid, this may involve partnering with the local regional collaborative care organization.

**Step 2: Track time from referral to intake for BH services with written protocol for patients not seen in a reasonable amount of time, as defined by practice.**

#### Action Items

1. Create a written protocol to track referrals and referral uptake/completion for offsite BH services. Include a definition of a “reasonable time” that makes sense for the practice and patients, and delineate a care team member to be responsible for tracking this process. Helpful information to track with this process includes: the time a referral is made, primary care record exchange with the behavioral health specialist, documentation of releases of information for bidirectional communication, when the initial visit occurs, preliminary treatment plan or plan for services, and when the visit summary is received by the primary care practice.
2. If the volume of referrals seems excessive, consider limiting referral tracking to a logical subset of the practice’s patients such as urgent or emergent referrals, referrals of high risk patients, or referrals to the most common BH providers/locations.

#### **Activity B**

**Step 1: Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve patient care coordination, one of which for primary care must be a BH provider.**

#### Action Items

1. Review templates for creating a care compact are in the SIM Toolkit.
2. Based on the needs of your practice and patient panel determine a beneficial BH/specialty provider practice with whom to develop a care compact.
3. Have a medical director or other clinic leader outreach to these BH/specialty providers to gauge interest in care compact agreements.

4. Work collaboratively with partners to create mutually beneficial care compact.

## Activity C

**Step 1: Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement - with numerator and denominator data - to assess impact and guide improvement in one of the following areas.**

- Notification of ED visit in timely fashion.
- Practice medication reconciliation process completed within 72 hours of hospital or neonatal intensive-care unit (NICU) discharge.
- Notification of admission and clinical information exchange at the time of admission.
- Notification of discharge, clinical information exchange, and care transition management at hospital and NICU discharge.
- Information exchange between primary care and specialty care related to referrals to specialty care.

**Step 2: Select one of the two options below, building on your earlier activities:**

- Contact at least 75% of patients or their families with ED visits within one week.
- Contact at least 75% of patients or their families who were hospitalized in target hospitals or NICU's, within 72 hours.

## Action Items

1. Select an area of focus based on the patient population. A [Plan-Do-Study-Act \(PDSA\) Tool](#) is included in the SIM Toolkit, and can be used to break the process down so it can be measured.

## Pediatric Notes:

- For all newborns, primary care visits at 72 hours and 2 weeks is best practice. This allows management of medication, DME, and care for postpartum depression to be established with the primary care practice and with any specialists involved in the care of the child and/or family.

## **Building Block 10: Integration and Compensation Reform**

### Overview

The intent of this building block is to utilize the skills developed in the other building blocks to move along the continuum towards full behavioral health integration, adoption of value-based payment methods, and links with community-based organizations to address public health issues for populations of patients in the practice.



Integrated health care means the systematic coordination of physical and behavioral health. The central premise is that physical and behavioral health problems often occur at the same time and often present in primary care practices before they present in any other formal setting. Employing universal screening processes for behavioral health issues and psychosocial adversity factors in an integrated primary care setting will produce the best results and will afford the most effective approach for all individuals.

Implementing integrated behavioral health and primary care services along with the other Colorado SIM milestone activities depends on the evolution of payment systems to ensure that advanced primary care activities are sustainable over time. Aligning practice payment with these activities to show improved health outcomes and cost reductions is a key element identified in The Colorado Framework. Building on Colorado's longstanding multi-payer collaborative, insurers have committed to supporting the goals of SIM, including speeding the expansion of value based payments, also called alternative payment methods (APMs). Practices, with help from Practice Facilitators, CHITA's and other SIM resources, can take steps to be ready for these new reimbursements.

Another of SIM's goals is to improve the connection between primary care practices and their local public health organizations and other community groups. These groups play an important role in addressing needs of local populations, but primary care practices rarely have opportunities to engage directly with them. Interactions between primary care and community groups can be mutually beneficial: community organizations are highly effective in addressing issues like social determinants of health that primary care clinics find difficult or impossible to impact, and primary care practices have resources, expertise, and relationships that can enhance public health activities.

## **Activity A**

**Step 1: Practice leadership receives education on implementing models of advanced access to BH services that includes financial, and operational considerations of the different options.**

**Step 2: Practice attests to practice and system support for advanced access to BH integration services, either onsite or remote, and demonstrates support through written policies and procedures to create a culture integrated, team-based care.**

**Step 3: Demonstrate advanced access to BH services provides:**

- Real-time and preplanned direct patient interactions for prevention and health promotion, diagnostic support, crisis management, and coordination of ongoing treatment plan.
- Preplanned joint consultation with BH provider, primary care provider and patients/families.
- Real-time and asynchronous consultation with primary care team members.

- Ongoing practice support to develop workflows and practices systems necessary for integrated models of care.

#### Action Items

1. Identify the level of BH integration that the practice is able/willing to aspire to according to SAMHSA and AHRQ levels of Collaboration/Integration.
  - Coordinated
  - Co-located
  - Integrated

Resources can be found in the SIM Toolkit. Completing the IPAT assessment on the SPLIT website can also help assess your current state of practice.

2. Leadership of the practice to identify scope of practice/population needs, FTE needs, electronic medical record sharing needs, supervision needs to accomplish level of integration desired.
3. Practice to identify policies and procedures on how crisis intervention, urgent, and emergent care episodes are handled between physical health and behavioral health providers whether they are in different sites, co-located, or can be accessed with a warm-hand-off.
4. Practice to identify procedures for how real-time or asynchronous consultation with behavioral health providers will occur. For CMHCs, practice identifies comparable procedures for how real time or asynchronous consultation with primary care providers will occur.
  - a. Which type of BH provider is available, when, and how (phone, in person, or via tele system; immediate access, warm hand-off, or appointment based).
  - b. What are the after-hours procedures for BH crisis intervention and when to involve BH providers?
  - c. How are warm-hand-offs handled in the practice and what is the follow-up plan to ensure that consultation and treatment has occurred?
  - d. How are BH providers accessed and scheduled? Practices will need to establish schedules that allow for the desired level of integration and adhere to billing and documentation procedures that reflect the type of service provided. For example, fully integrated BH providers may document in the medical records of patients seen in the primary care setting without documenting anything additional in separate behavioral health records.
5. Practice to identify how treatment planning will be completed, addressing physical and behavioral health needs and communicated among providers and with patients and families.

- a. Workflows can be designed to enhance communication and shared treatment planning if all treating providers play a role in documentation and communication about a patient.
  - b. Providers may require training in communicating about physical and behavioral health needs, particularly if new tools (e.g., templates, forms, protocols) are being implemented.
  - c. A practice may develop templates that allow for documentation of physical and behavioral health needs and recommendations for treatment.
6. Practice to identify workflows of how behavioral health conditions and other chronic conditions will be screened for and how the results will be communicated to the providers.
  - a. A practice may develop screening protocols that necessitate BH provider treatment following a particular response pattern. For example, an elevated pregnancy-related depression screener may trigger an automatic consultation with a BH provider.
  - b. Depending on the record keeping system, alerts and workflow notifications can be designed to facilitate communicating results to providers. Positive screens may trigger immediate responses depending on the level of severity and whether any safety concerns arise.
  - c. A practice can identify/designate the appropriate staff to respond and initiate protocols related to different types of screening outcomes.
7. The practice will identify what and how BH screening occurs and what tools will be used. The SIM Toolkit will have many screening tools available for review.
8. The practice will identify who will do what screening, the interface with the electronic record and how results are communicated both internally to the practice and with external resources should referrals need to be made.
9. The practice will develop protocols for assuring that behavioral conditions that are identified through screening are systematically dealt with through treatment, referral, and/or monitoring.

## **Activity B**

Goal: Develop experience with value-based payment, also called alternative payment methods (APMs), and begin to increase the proportion of the practice's income that comes from APMs rather than fee-for-service (FFS).

Objective 1: The practice will gain experience with accepting an APM, setting goals, using quality improvement methods to track performance in meeting the goal/target and actually reach the target and receive good compensation.

Objective 2: Later in the SIM timeline the practice will gain additional experience with other common APMs and continue to increase value-based payment.

**Step 1: Practice accepts non-fee for service payments.**

Action Items

1. Review the materials in the SIM Toolkit that describe the types of non-fee-for-service payment methods, also called “alternative payment methods”.
2. Identify the APMs that are available to available to them from various payers.
3. Select one APM to engage with and focus on for improvement. Ideally select one that rewards activities or outcomes that the practice is already working on as part of SIM and rewards an outcome that interests the practice.
4. Determine how they will measure the goal or target specified in the APM and how they will monitor and document improvement.
5. Develop a specific processes to accomplish measurement and documentation of improvement on the parameter(s) associated with the APM. For example, if the practice selects a per-member-per-month (PMPM) APM for incorporating a specific activity into the practice, develop a process for incorporating that process and meeting all associated expectations. Also develop a process to document compliance or measure success.
6. Regularly review progress on completing these activities.

**Step 2: Practice receives the majority of its financing through value-based payments.**

Some practices participating in the SIM initiative will not have the opportunity to receive the majority of their income through value-based payments because of circumstances outside of their control. It is included as a SIM activity because experiences in other primary care settings have shown that practices who can achieve a majority of revenues through value based payments experience a tipping point, allowing more rapid and sustainable advances in caring for their patients.

Action Items

1. List the types of APMs practice is paid by health plans and estimate what percent of their practice income comes through APMs.

**Activity C**

**Step 1: Practice engages at least one public health or community organization to make improvements in a mutual population health goal.**

Action Items

1. Work with your Practice Facilitator and Regional Health Connector (if possible) to identify a problem, barrier or issue of interest to the practice that affects a population of patients in their practice. For ideas on choosing an issue, consider aligning with a problem/issue identified in the practice's [local public health improvement plan](#) or a priority being addressed in other building blocks.
2. Decide what problem (population health goal) the practice leadership team would like to address that they believe they could find a community resources organization to help with.
3. Develop a method of identifying patients with the problem or issue. For example using a screening tool, a registry, or both.
4. Identify and connect with a community based organization that can help address the problem. Talk with an appropriate representative from the organization. Determine if they can actually serve as an appropriate resource for the patients in the practice or community.
5. Develop a plan with the community resource organization to coordinate activities in a manner to address the problem. Include a method with the community organization to “close the loop,” to check that the patient actually connected with the community organization and received services.
6. Develop a method to determine whether the patient actually improved and a procedure for handling the situation in which the patient did reach the community organization or did not improve.

Some examples of concerns and corresponding organizations might include:

- Identify patients overusing alcohol and identify a community-based treatment program. Arrange a referral process and feedback loop to “close the loop.”
- Identify a local nutrition counseling/obesity treatment program for patients willing to utilize that approach to obesity.
- Identify a local food bank able to assist families with food insecurity.
- Identify a community-based organization with personnel specifically trained in pregnancy-related depression and organize pregnancy related depression screening in the practice, linking patients who screen positive to the community group.
- Become a member of a local health alliance and collaboratively address a community wide health issue.

## Colorado SIM Practice Reporting Overview

Practices will complete a variety of assessments at baseline and at periodic intervals. The reporting tools, summarized in this section and in Appendix B, assess various aspects of transformation which are important to achieving the goals of SIM.

Assessment Tools	Purpose	Who Fills it Out	Responsible for Reporting	Timing	Expected Time to Complete (Minutes)
<b>Medical Home Practice Monitor</b>	Practice self-assessment of level of implementation of core aspects of advanced primary care	Practice Team led by PF	Practice Champion	Baseline & every 6 months	60
<b>Integrated Practice Assessment Tool (IPAT)</b>	Assesses current methods BHI along levels of coordination, co-location and integration	Practice Champion	Practice Champion	Baseline & annually	10
<b>Clinician and Staff Experience Survey</b>	Individual provider and staff survey that assesses two subscales - Clinician and Staff Experience and Burnout	All members of Practice	Each practice member	Baseline & annually	15
<b>SIM Milestone Activity Inventory</b>	Assesses practice's current implementation of SIM milestone activities, helps identify gaps and prioritizes practice's next steps	Practice Team led by PF	Practice Team submits draft, PF submits final	Baseline & every 6 months	60
<b>Data Quality Assessment</b>	Assesses practice's current state of data quality including accuracy of data element capture, validity of CQM reports and desired next steps for HIT	Practice HIT Champion led by CHITA	CHITA	Baseline & every 6 months	60
<b>Practice Improvement Plan</b>	SMART goals related to practice transformation as it relates to milestone activities; Can be done at same time as inventory	Practice Team led by PF	PF	Baseline & every 6 months	15
<b>Clinical Quality Measures</b>	Track patient and process outcomes achieved by practices	Practice Champion	Practice Champion	Every calendar quarter starting Q2 2016	Variable

*PF: practice facilitator. CHITA: clinical health information technology advisor. HIT: health information technology.*

The assessment tools are designed to give a practice a better understanding of its current status or capacity. They also will help practices identify and prioritize issues that can be addressed during SIM and in future QI activities. These multipurpose reports will be used to help practices collaborate with their Practice Facilitator, Clinical Health Information Technology Advisor, and Regional Health Connector so that this SIM technical assistance team can better understand the practices' needs and efficiently tailor support.

Practices will complete the forms on the Shared Practice Learning and Improvement Tool (SPLIT) - a web-based platform for collecting reports, organizing summaries, and tracking changes over time which will be available in February 2016.

## **Colorado SIM Milestone Activity Inventory**

The SIM Milestone Activity Inventory was developed to help practices assess their current status related to each milestone activity outlined in this Implementation Guide and will be completed by each practice twice annually. SIM recognizes that many practices have already invested substantial time and resources on practice transformation related activities, and other practices are in earlier stages of this process. The SIM Milestone Activity Inventory will help practices, Practice Facilitators and Clinical Health Information Technology Advisors understand which milestone activities are already well established within a practice, which milestone activities are currently underway and need continued work, and which milestone activities a practice is not currently addressing. The Milestone Activity Inventory will serve as a roadmap to guide the practice to set SIM activity priorities/goals and focus efforts on activities that are the most meaningful for the practice. The SIM Milestone Activity Inventory will also provide reporting to the SIM Office regarding each practice's progress with the milestone activities over the course of their involvement with the initiative.

SIM milestones are organized by building blocks (1-10), activities (A-D) and steps (1-3). SIM does not require that practices achieve all the milestones activities and steps by a certain time. Practices will work through the milestones at their own pace, choosing which milestones to focus on based on their local priorities and resources.

At baseline and every 6 months practices will complete the SIM Milestone Activity Inventory to document the current status of milestone implementation and track progress over time. Answers will translate to a report indicating red (have not started),

yellow (in progress), green (process established) ratings for each milestone to help practices identify strengths and focus future priorities. In items where answers are binomial, for example just yes or no as optional answers, there may only be categories of red and green. Some items included in the inventory will not receive a red, yellow, green score, but provide context for using the inventory to support practice transformation and the SIM milestones.

From this overview, practices will choose milestones to prioritize in the following 6 months. This information will also help the clinic’s Practice Facilitator and Clinical Health Information Technology Advisor tailor their support to the individual needs of the practice.

The SIM Milestone Activity Inventory will be completed on the SPLIT and the resulting assessment report will be automatically scored and populated with red, yellow, green indices. Below, scoring criteria for red, yellow, green status are described for reference.

**Building Block 1: Engaged Leadership**

**Activity A**

**Step 1 - Practice completes all SIM practice and practice member assessments based on SIM Office timelines.**

<b>Baseline Assessments</b>	<b>Complete &amp; Submitted</b>	<b>In progress</b>	<b>Not yet started</b>
Medical Home Practice Monitor			
Practice Improvement Plan			
Data Quality Assessment			
Milestone Activity Inventory			
Clinician and Staff Experience Survey			
IPAT			

<b>6 Month Assessments</b>	<b>Complete &amp; Submitted</b>	<b>In progress</b>	<b>Not yet started</b>
Medical Home Practice Monitor			
Practice Improvement Plan			
Data Quality Assessment			
Milestone Activity Inventory			

<b>12 Month Assessments</b>	<b>Complete &amp;</b>	<b>In</b>	<b>Not yet started</b>
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	Submitted	progress	
Medical Home Practice Monitor			
Practice Improvement Plan			
Data Quality Assessment			
Milestone Activity Inventory			
Clinician and Staff Experience Survey			
IPAT			

18 Month Assessments	Complete & Submitted	In progress	Not yet started
Medical Home Practice Monitor			
Practice Improvement Plan			
Data Quality Assessment			
Milestone Activity Inventory			

Final (24 Month) Assessments	Complete & Submitted	In progress	Not yet started
Medical Home Practice Monitor			
Practice Improvement Plan			
Data Quality Assessment			
Milestone Activity Inventory			
Clinician and Staff Experience Survey			
IPAT			

*Automatic scoring will result in green if all assessments for the current assessment period are indicated as “complete and submitted”, yellow if any are marked “in progress”, and red if all the assessments are marked “not yet started”.*

### Activity B

**Step 1 - Primary care practice champions receive training on continuum of BH services and advanced BH integration strategies. SIM bidirectional health home champions receive training on continuum of primary care strategies.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

### Activity C

**Step 1 - Practice completes an annual budget or forecast with projected new SIM revenue flow and plan for anticipated practice expenses associated with practice redesign and integration activities.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

When was the last annual budget or forecast completed? (Enter date)

#### Activity D

**Step 1 - Fully engage and cooperate with ongoing evaluation and technical assistance deliverables as defined by SIM Office.**

How has your practice interacted with your practice facilitator? (Select all that apply)

- We have not interacted with our practice facilitator yet
- In person meetings at least monthly
- Email
- Phone calls
- Other (specify)

How has your practice interacted with your Clinical Health Information Technology Advisor (CHITA)? (Select all that apply)

- We have not interacted with our CHITA yet
- In person meetings at least monthly
- Email
- Phone calls
- Other (specify)

How has your practice interacted with the Regional Health Connector in your area? (Select all that apply)

- We have not interacted with our local Regional Health Connector yet
- In person meetings at least monthly
- Email
- Phone call(s)
- Other (specify)

*Automatic Scoring: Red, all three questions are 'we have not interacted yet, Yellow, some contact noted for either PF or CHITA or RHC, green some contact noted for PF CHITA and RHC*

## **Building Block 2: Data Driven Improvement Using Computer-Based Technology**

### **Activity A**

**Step 1: Practice completes and submits baseline assessment to determine data capacity.**

Has the baseline Data Quality Assessment been completed?

a) Yes, No - in progress, No - not started, Not sure

*\*This only refers to baseline data quality assessment.*

*Automatic Scoring: Red, Data Quality Assessment not started, yellow, in progress, green, complete*

**Step 2: Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry, practice management or EHR system to drive clinical practice improvement.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

1. Number of reports used regularly for clinical practice improvement (allow selection of 0-10+)

2. Practice has reports that analyze:

- Utilization
- Quality metrics
- Billing data
- Panel size
- Demographics
- Tests ordered
- Other (free text)

3. Reports are generated and reviewed:

- Weekly
- Monthly
- Quarterly
- Other (free text)

## Activity B

**Step 1: Practice trains 50% of staff in improvement methods and tools and forms QI team that meets regularly.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

What percentage of staff have been trained in improvement methods and tools?  
(Percentage)

Does your practice have a QI team?

- Yes/no

*If no - skip to next step. If yes:*

How often does your QI team meet?

- Weekly
- Twice a month
- Monthly
- Less often than once a month

**Step 2: Practice incorporates regular improvement methodology to execute change ideas in a rapid cycle. Document a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

Which of the following QI methodologies have been used in your practice in the last 6 months? Select all that apply.

- 5 Whys
- Agendas
- Aim Statement
- Brainstorming
- Model for Improvement
- Documented PDSA cycles

- Fishbone diagrams
- Process mapping
- Quality measure performance reports
- SMART Goals
- Strategic planning
- SOMETHING ELSE (please describe):

### Activity C

**Step 1: Practices selects the clinical quality measure (CQM) group that best aligns to their patient population and transformation priorities.**

Based on your patient population, which CQM group will you use for SIM CQM reporting?

- Pediatric
- Adult/Family

*Automatic Scoring: This activity will turn green when this answer is saved.*

**Step 2: Practice meets SIM Office CQM reporting requirements.**

Practices will be asked to indicate if they can currently report the CQMs corresponding to their CQM group (previous question). If they are not able to report a CQM currently, then a follow up question will ask when they expect to be able to report that CQM. Refer to Appendix C for a breakdown of CQM measure groups.

*Automatic Scoring: Red, all CQM answers are No and Other/Unknown, yellow, any (but not all) answers are No and Other/Unknown, green, all answers are YES*

**Step 3: Practice uses automated data extraction through health information exchange (HIE) to supply data for SIM CQM reporting.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

### Activity D

**Step 1: At least quarterly, use data hub benchmark reports to inform continuous quality improvement on at least three clinical quality measures (CQMs).**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)

Well established workflow already in place (green)

Is a practice champion familiar with the SIM Quality Measure Reporting Tool's (QMRT) and its practice performance reports?

a) Yes/No

How often does your QI team review the Quality Measure Reporting Tool's (QMRT) practice performance reports?

Never

Monthly

Quarterly

Every 6 months

Other (free text)

### **Building Block 3: Empanelment**

#### **Activity A:**

**Step 1: Practice documents strategy to achieve and maintain empanelment to provider and care teams.**

**Step 2: Achieve and maintain 80% empanelment to provider and care teams.**

**Step 3: Achieve and maintain at least 95% empanelment to provider and care teams.**

The practice has chosen an empanelment method.

a) Yes/No

*If No skip to the next activity. If "Yes", step 1 will be green and practice proceeds to next question.*

Percent of patients that are empaneled to providers and/or care teams

0 - 40%

41 - 60%

60-80%

80 - 95%

>95%

*Step 1 automatic scoring: Red if "No" to empanelment method. Green if "Yes".*

**Step 2 automatic scoring:**

- Red if practice does not have an empanelment method.
- Yellow - “Yes” to empanelment method and selects 0-40%, 41-60%, or 61-80%
- Green: “Yes” to empanelment method and selects 81-95% or >95%

**Step 3 automatic scoring:**

- Red if practice does not have an empanelment method.
- Yellow - “Yes” to empanelment method and selects 0-40%, 41-60%, 61-80% or 81-95%
- Green: “Yes” to empanelment method and selects >95%

**Activity B**

**Step 1: Practice periodically reviews attribution lists provided by payer(s) to reconcile discrepancies.**

How many payers have sent attribution lists to your practice to review?

Choose a number 0-10+

*If “0” skip to Building Block 4*

*If 1+ then proceed.*

*Autoscore: Red if 0; Red/Yellow/green see below.*

Does your practice have a process established with payers to review attribution lists and reconcile discrepancies between your internal patient panel and the payer attribution lists?

- No process in place (red)
- Some work on this has been done but could be improved (yellow)
- Well established workflow already in place (green)

**Step 2: Practice achieves 70% concordance between internally empaneled patients and payer attribution lists.**

What is the concordance between the practices internal patient panel and the payer attribution lists which you reviewed?

- 0 - 50% (yellow)
- 51 - 70% (yellow)
- 71-90% (green)
- >90% (green)

Not sure (*red*)

## **Building Block 4: Team Based Care**

### **Activity A**

**Step 1: Practice periodically (baseline and at least annually) reviews assessment of distribution of patient care tasks by role.**

**Step 2: Practice better distributes workload throughout the team in ways that makes optimal use of team members' training and skill sets.**

Which description best applies to these milestones as a grouping:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

Practice has written policies and procedures patient care tasks duties by role:

a) Yes/No

Practice has completed an assessment of the distribution of patient care tasks by role.

- a) Yes/No
- b) IF YES: date of last assessment

### **Activity B**

**Step 1: Practice implements at least one of the following team-based care strategies:**

- Daily team huddles to plan for patient visits
- Collaborative care planning sessions
- Standing orders

**Step 2: Practice implements at least two of these activities.**

Which of these tactics does your practice use to better distribute workload throughout the team? (Mark all that apply)

- Daily team huddles to plan for patient visits
- Collaborative care planning sessions



- Standing orders and other standardized protocols
- None of the above (*red*)

If “None of the above” - skip to next activity.  
 Autoscore: Yellow and Green - see below.

**Daily Huddles (if chosen)**

How often do Daily Team Huddles occur?

- At least daily (*Green*)
- 3-4 days a week (*green*)
- 1-2 days a week (*yellow*)
- Less than once a week (*yellow*)

How long do Daily Team Huddles meet?

- < 5min
- 5-10 min
- 10 - 15 min
- >15 min

Who is included in the daily team huddles?

- |   |   |
|---|---|
| <input type="checkbox"/> Provider (MD, DO, PA, NP)  | <input type="checkbox"/> Front office/receptionist    |
| <input type="checkbox"/> RN/LPN                     | <input type="checkbox"/> Office staff/medical records |
| <input type="checkbox"/> MA/CNA                     | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Care coordinator           |   |
| <input type="checkbox"/> Behavioral Health Provider |   |
| <input type="checkbox"/> Pharmacist                 |   |

**Collaborative care planning sessions (if chosen)**

1. How often do collaborative care planning sessions occur?

- Weekly (*green*)
- Monthly (*green*)
- Quarterly (*green*)
- Less often than quarterly (*yellow*)

2. How long do collaborative care planning sessions take?

- <15 min
- 16 - 30 min
- 31 - 45 min
- 60 - 90 min

> 90 min

3. Who is included in the collaborative planning sessions?

- |   |   |
|---|---|
| <input type="checkbox"/> Provider (MD, DO, PA, NP)  | <input type="checkbox"/> Front office/receptionist    |
| <input type="checkbox"/> RN/LPN                     | <input type="checkbox"/> Office staff/medical records |
| <input type="checkbox"/> MA, CNA                    | <input type="checkbox"/> Patient and/or family        |
| <input type="checkbox"/> Care coordinator           | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Behavioral Health Provider |   |
| <input type="checkbox"/> Pharmacist                 |   |

**Standing orders and standardized protocols (if selected)**

1. Practice has standing orders or standardized protocols for:

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes labs and other orders   | <input type="checkbox"/> Medication refills   |
| <input type="checkbox"/> Symptom based tests (i.e. pregnancy tests, rapid strep tests, urine dipsticks) | <input type="checkbox"/> Medication adjustments (i.e. insulin, blood pressure medications, anticoagulation) |
| <input type="checkbox"/> ADHD   | <input type="checkbox"/> Other (free text)  |
| <input type="checkbox"/> Preventative screening   | <input type="checkbox"/> No standing orders are used  |
| <input type="checkbox"/> Immunizations  |   |

*Automatic score for standing orders: Red if “no standing orders are used”; Yellow 1-2 checked; Green 3+ checked*

*Automatic score for step 1: Green if any one of the activities is green; Yellow if 1 or more are yellow*

*Automatic score for step 2: Green if 2 or more of the activities are green; Yellow if 2 or more are yellow*

### Activity C

**Step 1: Demonstrate that individualized patient treatment plans that include both physical and behavioral health goals of care are accessible in the practice’s EHR.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

Care Plans are available in EHR and contain goals both physical and behavioral health goals

- a) Yes/No

Can providers and staff in the practice access individualized patient treatment plans in the EHR?

- a) Yes - all providers and staff have access
- b) Yes - Some providers and staff have access
- c) No - our treatment plans are not accessible in the EHR

Which roles contribute to individualized patient treatment plans? (Mark all that apply.)

- |   |   |
|---|---|
| <input type="checkbox"/> Provider (MD, DO, PA, NP)            | <input type="checkbox"/> Front office/receptionist  |
| <input type="checkbox"/> RN/LPN                               | <input type="checkbox"/> Other office staff   |
| <input type="checkbox"/> MA/CNA                               | <input type="checkbox"/> Patients and/or their families   |
| <input type="checkbox"/> Care coordinator                     | <input type="checkbox"/> External medical specialists   |
| <input type="checkbox"/> Onsite behavioral health provider(s) | <input type="checkbox"/> External community providers (i.e. school counselor, pastor providers (describe) |
| <input type="checkbox"/> External behavioral health providers | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Pharmacist                           |   |

How frequently are individualized patient treatment plans and goals reviewed with patients or their families?

- Never/rarely
- Monthly
- Quarterly
- Annually
- Other \_\_\_\_\_

How frequently are individualized patient treatment plans updated in the EHR?

- Never/rarely
- Monthly
- Quarterly
- Annually
- Other \_\_\_\_\_

## Activity D

**Step 1: Participate in SIM bi-annual Collaborative Learning Session. Serve as peer presenter at Collaborative Learning Sessions when requested.**

How often has a practice member participated as a presenter or panel member at a SIM bi-annual Collaborative Learning Sessions?

a) Here a practice would enter a number

*Automatic Scoring: Red, 0; yellow, 1-3; green, 4 or more.*

What suggestions do you have for future SIM Collaborative Learning Sessions topics?

a) Free text (optional)

## **Building Block 5: Patient Team Partnership**

### Activity A

**Step 1: Implement self-management support for at least three high risk conditions.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

For which populations does your practice provide targeted self-management support to patients or their families? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> ADHD                        | <input type="checkbox"/> Hypertension              |
| <input type="checkbox"/> Autism                      | <input type="checkbox"/> Congestive heart failure  |
| <input type="checkbox"/> Pregnancy                   | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Early childhood care        | <input type="checkbox"/> Chronic pain              |
| <input type="checkbox"/> Hospital or NICU discharges | <input type="checkbox"/> Substance abuse disorders |
| <input type="checkbox"/> Obesity                     | <input type="checkbox"/> Other (free text)         |
| <input type="checkbox"/> Diabetes                    |  |

Select the tactics your practice uses to support self-management across conditions.

Select all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Between visit care planning    | <input type="checkbox"/> Agenda planning                                   |
| <input type="checkbox"/> Health coaching at visits      | <input type="checkbox"/> Identify, document and follow up on patient goals |
| <input type="checkbox"/> Health coaching between visits |  |

- |   |   |
|---|---|
| <input type="checkbox"/> Peer-led support for self-management             | <input type="checkbox"/> 5 As                 |
| <input type="checkbox"/> Group visits                                     | <input type="checkbox"/> Reflective Listening |
| <input type="checkbox"/> Evidence based counseling: check all that apply: | <input type="checkbox"/> Teach Back           |
| <input type="checkbox"/> Motivational Interviewing                        | <input type="checkbox"/> Other: (free text)   |
|   | <input type="checkbox"/> Other: (free text)   |

## Activity B

**Step 1: Implement shared decision making tools or aids for two health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in CMHC must be related to physical health.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing at this time - skip to next step. If some work or well establish - complete the following question:*

**For which health conditions, decisions or tests has your practice implemented shared decision making approaches?**

- |  |  |
|--|--|
| <input type="checkbox"/> Therapeutic options in management of obesity  | <input type="checkbox"/> Therapeutic options in management of menopausal symptoms  |
| <input type="checkbox"/> Therapeutic options in management of acute sinusitis                                      | <input type="checkbox"/> Therapeutic options in management of mild anxiety   |
| <input type="checkbox"/> Therapeutic choices in management of asthma   | <input type="checkbox"/> Therapeutic options in management of mild depression  |
| <input type="checkbox"/> Behavioral and therapeutic choices for family planning                                    | <input type="checkbox"/> Therapeutic options in management of postpartum depression                                      |
| <input type="checkbox"/> Therapeutic choices in management of ADHD   | <input type="checkbox"/> Therapeutic options in management of urinary incontinence                                       |
| <input type="checkbox"/> Diagnostic and therapeutic management of acute low back pain without high risk indicators | <input type="checkbox"/> Therapeutic options in management of functionally significant osteoarthritis of the hip or knee |
| <input type="checkbox"/> Therapeutic options in management of insomnia   |  |
| <input type="checkbox"/> Therapeutic options in management of chronic pain   |  |

- Medication choices in management of congestive heart failure
- Medication choices in management of COPD
- Medication choices in management of diabetes
- Anticoagulation in atrial fibrillation

- Prostate cancer screening
- Screening mammography age 40 - 49
- Colon cancer screening strategies
- End of life preferences
- Other 1 (specify)
- Other 2 (specify)
- Other 3 (specify)

**Step 2: Track use of shared decision making aids using one of the following methods:**

- A metric tracking the proportion of patients and families eligible for the decision aid who receive the decision aid; OR
- Quarterly counts of patients and families receiving individual aids.

How does your practice track the use of shared decision making aids?

- We are not tracking the use of shared decision making aids at this time (*red*)
- Using a metric tracking the proportion of patients and families eligible for the decision aid who receive the decision aid
- Using quarterly counts of patients and families receiving individual aids
- Other (describe)

*Auto Scoring: Red, not tracking, no yellow in this category, green, choosing any of these 3 options.*

### Activity C

**Step 1: Assess and improve patient and family experience of care by selecting at least one of the following**

- Regular patient and family surveys at least quarterly.
- Patient and family advisory council that meets at least quarterly.

How does your practice currently assess patient and family experience of care? (Mark all that apply)

- Regular patient and family surveys at least quarterly.
- Patient and family advisory council that meets at least quarterly.
- None of the above

*If none of the above - go to next step/activity.*

*Automatic Scoring: Red if none of the above, yellow and green described below. If they choose both surveys and councils - automatic scoring must meet green criteria*

for both surveys and advisory councils for the whole activity to be green. If one is yellow and the other green, then the activity is yellow.

**Patient and family surveys (If selected)**

Which description best applies to patient and family surveys:

- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

Method of patient and family surveys

- Our practice uses a survey developed or adapted to address our specific questions
- Our practice used a commercially available survey administered by a vendor (Describe which one)

How is the survey administered? Select all that apply:

- Distributed and collected during office visit
- Mailed to patients
- Telephone survey of patients
- Use of online survey tool
- Distributed via Patient Portal
- Other (specify)

Frequency of surveys:

- Weekly
- Monthly
- Every other month
- Quarterly
- Other (describe)

**Patient and family advisory council that meets at least quarterly (if selected)**

Which description best applies to patient and family surveys:

- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

How often has your PFAC in the last year? (Enter number)

**Step 2: Develop communication(s) to patients, families, and the clinic about the specific changes the practice is implementing (e.g. a pamphlet or posters), including the efforts related to integrated care as a result of, or influenced by, practice survey/PFAC activities.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

Indicate how your practice is communicating the changes that you are making based on patient and family feedback. Select all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Waiting room communication (e.g., poster, video) | <input type="checkbox"/> Mailing to patient   |
| <input type="checkbox"/> Hand-out/brochure given to patient in office     | <input type="checkbox"/> Public reporting through local or regional collaboratives/press releases           |
| <input type="checkbox"/> Website/Patient portal                           | <input type="checkbox"/> Newsletter or other communication distributed to patients outside of office visits |
| <input type="checkbox"/> Social media (e.g., Facebook, Twitter)           | <input type="checkbox"/> Other (specify)  |
| <input type="checkbox"/> Phone hold messages                              |   |
| <input type="checkbox"/> Written reminder on visit summary or care plan   |   |

Identify the types of practice changes in the last quarter were influenced by the survey or PFAC. Select all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Changes to scheduling, hours, appointment types                                 | <input type="checkbox"/> Using community-based self-management support and wellness resources                               |
| <input type="checkbox"/> Changes to front office staffing and waiting areas                              | <input type="checkbox"/> Strategies to improve continuity of care and relationship between patients and providers/care team |
| <input type="checkbox"/> Refinements to risk stratification methodology                                  | <input type="checkbox"/> Tracking and follow-up from hospitals and diagnostic studies                                       |
| <input type="checkbox"/> Changes in the development or use of the plan of care for patients at high risk | <input type="checkbox"/> Transition of care from hospitals and subacute care  |
| <input type="checkbox"/> Changes to medication management strategies                                     | <input type="checkbox"/> Follow-up from ED visits   |
| <input type="checkbox"/> Changes to self-management support strategies                                   | <input type="checkbox"/> Coordination of care with specialists  |
| <input type="checkbox"/> Coordination of care with mental health and behavioral health providers         | <input type="checkbox"/> Physical layout or decorations of the clinic   |
|  | <input type="checkbox"/> Other: (specify)   |
|  | <input type="checkbox"/> Other: (specify)   |



## **Building Block 6: Population Management**

### **Activity A**

**Step 1: Indicate methodology used to assign risk status to every empaneled patient.**

Has your practice selected method to assign risk to empaneled patients?

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing: skip to next activity*

*If yes continue with these questions*

Indicate which method(s) most closely align to how you risk stratify your patients.

- Care team judgment: Providers and other care team members assign a risk category to individuals based on their knowledge of the patient in comparison to other patients in the practice panel.
- Algorithm: Each patient is given a risk score based on a predetermined equation that can combine multiple factors such as demographics, diagnoses, prescription medications, utilization, cost, biometrics, or social determinants.
- Threshold: Patients are determined to be in a high risk group once they meet certain conditions such as number of hospitalizations, number of ER visits, NICU discharge.

Which factors are used for your risk stratification method? (Select all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Unsure   | <input type="checkbox"/> Prescription drug information (i.e. number of medications or high risk categories) |
| <input type="checkbox"/> Care team judgment and intuition                                 | <input type="checkbox"/> ER utilization   |
| <input type="checkbox"/> Demographics (i.e. age, sex, race, ethnicity)                    | <input type="checkbox"/> Hospitalizations or NICU stays   |
| <input type="checkbox"/> Social determinants (i.e. schooling, job status, housing status) | <input type="checkbox"/> High cost imaging  |
| <input type="checkbox"/> Physical health diagnoses  | <input type="checkbox"/> Internal billing/charges information   |
| <input type="checkbox"/> Behavioral health diagnoses                                      | <input type="checkbox"/> Adjudicated insurance claims information   |
| <input type="checkbox"/> Biometrics (i.e. vital signs, lab results)                       | <input type="checkbox"/> Other (describe)   |

**Step 2: Establish and track metrics for percent assignment of risk status and proportion of population in each risk category.**

Which description best applies to this step:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

**Step 3: Continue to risk stratify all patients, achieving risk stratification of at least 75% of empaneled patients.**

What percentage of your patient panel has an assigned risk score or category?

- <25% (*Red*)
- 25 - 49% (*Yellow*)
- 50-74% (*Yellow*)
- >75% (*Green*)

## **Activity B**

**Step 1: Provide care management to at least 80% of highest risk patients.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved
- Well established workflow already in place

*If “not addressing at this time” skip to next activity*

*If some work or well established workflow then continue:*

What percentage of your highest risk patients receive care management?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%

*Automatic Scoring: yellow, up to 80%, green, greater than 80%*

**Step 2: Implement two or more of the following three specific care management strategies for patients in higher risk cohorts (beginning with those at highest risk):**

- Coordination of behavioral health services obtained outside of practice (required)
- Self-management support (SMS) for at least 3 high risk conditions, including one behavioral health condition.
- Medication management and review

Which care management strategies have you implemented? (Select all that apply.)

- Coordination of behavioral health services obtained outside of practice
- Self-management support (SMS) for at least 3 high risk conditions, including one behavioral health condition.
- Medication management and review
- None of the above.

*Automatic Scoring: Red, none of the above, yellow, one selected, green, 2 or more selected*

**Step 3: 80% of highest risk patients receiving care management services have an individualized patient treatment plan that includes both physical and behavioral health goals of care are accessible in the practice's EHR**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved
- Well established workflow already in place

*If not addressing - skip to next activity*

*If some work/well establish then:*

How many high risk patients currently have an individualized patient treatment plan that includes both physical and behavioral health goals of care?

- 0-20%
- 21-40%
- 41-60%
- 61-80%
- 81-100%

*Automatic Scoring: Yellow, 0-80%, green 81-100%*

### Activity C

**Step 1: In primary care, attest that 90% of patients are screened for at least one behavioral health condition for which the practice has a documented workflow to assist patients who screen positive.**

Which description best applies to this milestone step:

- Not addressing at this time (*red for step 1*)
- Some work on this has been done but could be improved
- Well established workflow already in place

*If not addressing - skip to next activity*

*If some work/well establish then:*

For which behavioral condition(s) are patients screened? (Select all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Depression in adolescents | <input type="checkbox"/> Autism                    |
| <input type="checkbox"/> Depression in adults      | <input type="checkbox"/> Childhood development     |
| <input type="checkbox"/> Postpartum depression     | <input type="checkbox"/> Sleep disorders           |
| <input type="checkbox"/> Bipolar depression        | <input type="checkbox"/> Dementia                  |
| <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Other cognitive disorders |
| <input type="checkbox"/> Tobacco use               | <input type="checkbox"/> Self-harm                 |
| <input type="checkbox"/> Inappropriate alcohol use | <input type="checkbox"/> Other 1 (name)            |
| <input type="checkbox"/> Other substance abuse     | <input type="checkbox"/> Other 2 (name)            |
| <input type="checkbox"/> Obesity                   | <input type="checkbox"/> Other 3 (name)            |
| <input type="checkbox"/> ADHD                      |  |

*Automatic scoring will show the ones selected in this check list. Then ask for those only:*

Does your practice have a documented workflow for patients who screen positive?

- Yes
- No

**Step 2: Measure and report reach of behavioral health (BH) screening and treatment activities.**

What percentage of the patients seen in your practice has been reached by a behavioral health screening or treatment intervention in the last quarter?

- <10% (*red for step 2*)
- 10-29% (*yellow for step 2*)
- 30-59% (*yellow for step 2*)
- 60-89% (*yellow for step 2*)
- >= 90% (*green for step 2*)

*Automatic scoring for step 1: Green: 1+ condition selected AND 1+ condition with a documented workflow AND step 2 answered >=90%. Yellow any other combination that is not red or green.*

**Activity D**

**Step 1: Practice uses a registry system to track outcomes of at least two subpopulations of patients. One system must focus on a behavioral health condition (i.e. depression, ADHD) and the other system may focus on another behavioral health condition, preventive needs (i.e. well child checks, age appropriate screenings), or a chronic medical condition (i.e. diabetes, asthma).**

How many registries does your practice actively track?

- 0
- 1
- 2
- 3
- 4
- 5 or more

*If "0": red for Activity D, Steps 1, 2 and 3. Skip all further Activity D questions.  
If 1+ continue:*

Which registry focused on behavioral health is currently available and will be used for SIM population management activities?

- No behavioral health registry available
- Depression in adolescents
- Depression in adults
- Postpartum depression
- Bipolar depression
- Anxiety
- Tobacco use
- Inappropriate alcohol use
- Other substance abuse
- Obesity
- ADHD
- Autism
- Childhood development
- Sleep disorders
- Dementia
- Other cognitive disorders
- Self-harm
- Other (describe)

Which other registry is available and will be used for SIM population management activities? This registry can focus on behavioral health, preventive care, or a chronic condition.

- |  |  |
|--|--|
| <input type="checkbox"/> No other registry available | <input type="checkbox"/> Sleep disorders           |
| <input type="checkbox"/> Depression in adolescents   | <input type="checkbox"/> Dementia                  |
| <input type="checkbox"/> Depression in adults        | <input type="checkbox"/> Other cognitive disorders |
| <input type="checkbox"/> Postpartum depression       | <input type="checkbox"/> Self-harm                 |
| <input type="checkbox"/> Bipolar depression          | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Hypertension              |
| <input type="checkbox"/> Tobacco use                 | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Inappropriate alcohol use   | <input type="checkbox"/> Congestive heart failure  |
| <input type="checkbox"/> Other substance abuse       | <input type="checkbox"/> Well child checks         |
| <input type="checkbox"/> Obesity                     | <input type="checkbox"/> Colon cancer screening    |
| <input type="checkbox"/> ADHD                        | <input type="checkbox"/> Breast cancer screening   |
| <input type="checkbox"/> Autism                      | <input type="checkbox"/> Immunizations             |
| <input type="checkbox"/> Childhood development       | <input type="checkbox"/> Other (describe)          |

Where are the registry data pulled from? (Select all that apply.)

- EHR
- Practice management tool
- Third party tool
- Custom analytics
- Other \_\_\_\_\_

*Autoscore: Green: Practice selects one registry from BH conditions AND one registry from other registries pick list. Yellow: Practice selects one registry from BH conditions OR one registry from other registries pick list. Red: both registry questions marked as “no registry available”.*

**Step 2: Practice uses the two registry systems to identify and proactively outreach to patients with gaps in care and/or not achieving guideline-based treatment goals.**

Which description best applies to this milestone step:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

**Step 3: Practice is able to show sustained improvement in the care of the two subpopulations.**

Has your practice seen sustained improvements for the two subpopulations you have identified?

- No sustained improvements have been seen for either subpopulation (*red*)
- Sustained improvements seen for one of the subpopulation (*yellow*)
- Sustained improvements seen for both subpopulations (*green*)

## **Building Block 7: Continuity of Care**

### **Activity A**

#### **Step 1: Track continuity with primary care provider and/or care team.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing skip to next activity*

*If some work/well establish then:*

How does your practice define continuity of care? Select all that apply:

- Number of office visits to empaneled provider/number of office visits to practice
- Number of office visits to care team/number of office visits to practice
- Number of office visits + non-visit communication with empaneled provider/number with practice
- Number of office visits + non-visit communication with care team/number with practice
- Other [text box will be provided]

How does your practice calculate continuity? Select all that apply:

- Number of office visits to assigned provider/number of office visits to practice
- Number of office visits to assigned care team/number of office visits to practice
- Number of office visits + non-visit communication with assigned provider/number with practice
- Number of office visits + non-visit communication with assigned care team/number with practice
- Other (specify)

## **Building Block 8: Prompt Access to Care**

### **Activity A**

**Step 1: Provide and attest to 24 hour, 7 days a week patient access to a practice representative that has access to practice’s medical record for patient advice and to inform care by other professionals, including behavioral health records if a behavioral professional is fully integrated in practice.**

Do your practice’s patients have 24-hour/7-day-a-week access to a care team provider who has real-time access to their electronic medical record?

Yes/No

*If the **No** response is selected this question will appear:*

When does your practice expect to have 24/7 access to your EHR for all practitioners covering calls after patient hours?

- Within three months
- Between three and six months
- More than six months

*Automatic Scoring: Green, yes, yellow, within 3-6 months, red, greater than 6 months*

Does your practice have an onsite (collocated or integrated) behavioral health professional?

Yes/No

If yes: Does your 24/7 access include access to behavioral health records?

Yes/No

## Activity B

**Step 1: Enhance access by implementing at least one asynchronous form of communication (e.g. patient portal, email, text messaging) and make a commitment for a timely response.**

Identify how your practice is providing enhanced asynchronous patient access (non-urgent care provided to patients outside of office visits). Select all that apply:

- Patients send and receive messages through a patient portal
- Web-enabled visits other than through a patient portal
- Secure email
- Text messaging
- Telemedicine/Remote monitoring
- Other (specify) (any of the above, green)



- In progress/we are currently building this capacity (Describe plans in free text) (yellow)
- Not currently in progress (red)

*If in progress or not currently in progress - skip to next activity*

*If any of the other options selected:*

Does your practice communicate to patients a standard turnaround time for responses to your asynchronous communication method(s)?

- Yes/No

*If yes: provide the language you use to communicate the turnaround time to your patients. Text box will be provided.*

## **Building Block 9: Comprehensiveness and Care Coordination**

### **Activity A**

**Step 1: Detail where patients access BH services outside of primary care practice. For SIM CBHC's, detail where patients access primary care services outside of the CBHC.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing:*

Identify the main barriers to detailing where patients access BH services outside the primary care practice, or primary care services outside of the CBHC?

*Then skip to next activity*

*If some work/well establish then:*

Where do your patients access behavioral health services? (Select all that apply)

- Through collocated or integrated BH services In our primary care practice
- Outside of our primary care practice (describe in free text)
- Not applicable, we are a CBHC practice

Where do your patients access primary care services? (Select all that apply)

- In our Community Mental Health Center
- Outside of our Community Mental Health Center (describe in free text)
- Not applicable, we are a primary care practice outside of a CBHC

**Step 2: Track time from referral to intake for BH services with written protocol for patients not seen in a reasonable amount of time, as defined by practice.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing, skip to next activity*

*If some work/well establish then:*

How does your practice a reasonable time for a patient to be seen? (Free text)

Does your practice have a written protocol if this expectation is not met?

- Yes
- No
- Currently being developed

How long is the average time between a patient referral to intake for behavioral health services?

- Less than 1 week
- 1-2 weeks
- 2-4 weeks
- 4-8 weeks
- >8 weeks

## Activity B

**Step 1: Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve patient care coordination, one of which for primary care must be a BH provider.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing, skip to next activity*

*If some work/well establish then:*

With which behavioral health providers have you created care compacts or collaborative agreements? (Select all that apply)

- We have not created a care compact or collaborative agreement with a behavioral health provider
- Psychiatry
- Psychology
- Community behavioral health center
- Other (describe)

With which other specialty types have you arranged care compacts or collaborative agreements? (Select all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> We have not created a care compact or collaborative agreement with a specialty provider | <input type="checkbox"/> Obstetrics/Gynecology                    |
| <input type="checkbox"/> Allergy   | <input type="checkbox"/> Oncology                                 |
| <input type="checkbox"/> Anesthesiology  | <input type="checkbox"/> Ophthalmology                            |
| <input type="checkbox"/> Cardiology  | <input type="checkbox"/> Orthopedic Surgery                       |
| <input type="checkbox"/> Dermatology   | <input type="checkbox"/> Otolaryngology                           |
| <input type="checkbox"/> Emergency Medicine/Emergency Department   | <input type="checkbox"/> Pain Management                          |
| <input type="checkbox"/> Endocrinology   | <input type="checkbox"/> Pathology                                |
| <input type="checkbox"/> Gastroenterology  | <input type="checkbox"/> Physical Medicine and Rehabilitation     |
| <input type="checkbox"/> General Surgery   | <input type="checkbox"/> Physical Therapy                         |
| <input type="checkbox"/> Hematology  | <input type="checkbox"/> PICU                                     |
| <input type="checkbox"/> Hospital  | <input type="checkbox"/> Podiatry                                 |
| <input type="checkbox"/> Infectious Disease  | <input type="checkbox"/> Pulmonology                              |
| <input type="checkbox"/> Nephrology  | <input type="checkbox"/> Radiology & Imaging                      |
| <input type="checkbox"/> Neurology   | <input type="checkbox"/> Rheumatology                             |
| <input type="checkbox"/> NICU  | <input type="checkbox"/> Urology                                  |
|  | <input type="checkbox"/> Other (specify)                          |
|  | <input type="checkbox"/> None of the above (explain in free text) |

## Activity C

**Step 1: Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement - with numerator and denominator data - to assess impact and guide improvement in one of the following areas.**

- Notification of ED visit in timely fashion.
- Practice medication reconciliation process completed within 72 hours of hospital or NICU discharge.

- Notification of admission and clinical information exchange at the time of admission.
- Notification of discharge, clinical information exchange, and care transition management at hospital and NICU discharge.
- Information exchange between primary care and specialty care related to referrals to specialty care.

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing, skip to next activity*

*If some work/well establish then:*

For which of the following activities does your practice measure impact? (Select all that apply)

- Notification of ED visit in timely fashion.
- Practice medication reconciliation process completed within 72 hours of hospital or NICU discharge.
- Notification of admission and clinical information exchange at the time of admission.
- Notification of discharge, clinical information exchange, and care transition management at hospital and NICU discharge.
- Information exchange between primary care and specialty care related to referrals to specialty care.
- Other (describe)
- None of the above

**Step 2: Select one of the two options below, building on your earlier activities:**

- Contact at least 75% of patients or their families with ED visits within one week.
- Contact at least 75% of patients or their families who were hospitalized in target hospitals or NICU's, within 72 hours.

Which option is your practice working on?

- Not addressing either option at this time (*red*)
- Contact at least 75% of patients or their families with ED visits within one week.
- Contact at least 75% of patients or their families who were hospitalized in target hospitals or NICU's, within 72 hours.

*If not addressing, skip to next activity*

*If contact after ER, hospitalizations, NICU stays:*

What percentage of patients are contacted within 72 hours of discharge from your targeted ER, hospital or NICU in the last quarter?

- 0-20%
- 21-40%
- 41-60%
- 61-75% (*0-75%, yellow*)
- 76-100% (*green*)

How does your practice obtain discharge information from an ER, hospital or NICU?  
Select all that apply:

- Phone
- Fax
- Email
- Health Information Exchange (HIE)
- Access to ER, hospital or NICU EHR or provider portal
- Other (specify)

## **Building Block 10: Integration and Compensation Reform**

### **Activity A**

**Step 1: Practice leadership receives education on implementing models of advanced access to BH services that includes financial, and operational considerations of the different options.**

Has your practice leadership received education on implementing models of advanced access to BH services that includes financial, and operational considerations of the different options.

- Yes (*green*)
- No (*red*)

**Step 2: Practice attests to practice and system support for advanced access to BH integration services, either onsite or remote, for at least three years and demonstrates support through written policies and procedures to create a culture integrated, team-based care.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)

Well established workflows and procedures already in place (*green*)

**Step 3: Demonstrate advanced access to behavioral health (BH) services provides:**

- Real-time and preplanned direct patient interactions for diagnostic support, crisis management, and coordination of ongoing treatment plan
- Preplanned co-consultation with BH provider, primary care provider and patients/families
- Real-time and asynchronous consultation with primary care team members
- Ongoing practice support to develop workflows and practices systems necessary for integrated models of care.

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing, skip to next activity*

*If some work/well establish then:*

Which advanced access BH services are provided in your practice? (Select all that apply)

- Real-time and preplanned direct patient interactions for diagnostic support, crisis management, and coordination of ongoing treatment plan
- Preplanned co-consultation with behavioral health provider, primary care provider and patients/families
- Real-time and asynchronous consultation with primary care team members
- Ongoing practice support to develop workflows and practices systems necessary for integrated models of care.

## Activity B

**Step 1: Practice accepts non-fee for service (a.k.a. value-based) payments.**

Does your practice accept non-fee for service (a.k.a. value-based) payments?

Yes/No

*Autoscore: If “No” mark steps 1 and 2 red and skip to Activity C. If “Yes” mark step 1 green and continue to Activity B, Step 2.*

**Step 2: Practice receives the majority of its financing through value based payments.**

What percentage of your practice's financing is obtained through non-fee-for-service (a.k.a. value-based) payments?

- 0% (*red*)
- 1-25%
- 26-50% (*1-50%, yellow*)
- 51-75%
- 76-100% (*51-100%, green*)

Please describe any barriers to your practice obtaining a greater proportion of its financing through non-fee-for-service (i.e. value-based) payments?

**Activity C**

**Step 1: Practice engages at least one public health or community organization to make improvements in a mutual population health goal.**

Which description best applies to this milestone:

- Not addressing at this time (*red*)
- Some work on this has been done but could be improved (*yellow*)
- Well established workflow already in place (*green*)

*If not addressing, skip to **Review and Prioritization Steps***

*If some work/well establish then:*

Has your practice met with your Regional Health Connector?

- Yes/no/not sure

What type of public health or community organization have you engaged?

- |  |   |
|--|---|
| <input type="checkbox"/> Local public health department                                  | <input type="checkbox"/> Community recreation center      |
| <input type="checkbox"/> State public health department                                  | <input type="checkbox"/> Fitness center                   |
| <input type="checkbox"/> Local health alliance   | <input type="checkbox"/> Local business group or employer |
| <input type="checkbox"/> Spiritual or religious group                                    | <input type="checkbox"/> Philanthropy organization        |
| <input type="checkbox"/> School (elementary, middle, high)                               | <input type="checkbox"/> Other (describe)                 |
| <input type="checkbox"/> School of higher education (i.e. community college, university) |   |

## **Review and Prioritization Steps**

*Practice will see their milestone grid automatically colored in based on the red/yellow/green descriptions defined above.*

Instructions: Review this grid. Milestones shaded GREEN means your practice has well-established, optimized workflows for the topics. Milestones shaded YELLOW means your practice has done some work on this topics but workflows or processes could be improved. Milestones shaded RED means your practice has not started to work on this topic.

You can always go back to update or edit responses if you think there has been a mistake.

Once you feel comfortable with your Inventory responses, work with your practice facilitator and Clinical Health Information Technology Advisor to select 2-4 milestones that you want to focus on in the next 6 months of SIM and save a DRAFT version of the document.

Before a final SIM Milestone Inventory can be submitted, your practice facilitator will need to confirm your responses and review the milestones you prioritized. Your practice facilitator will talk to you about any suggested changes they might have to your responses.



Colorado SIM Practice Milestones for Cohort 1

This table outlines the milestone activities for practices that engage in SIM practice transformation work. The activities are organized by the core concepts of primary care as outlined in the 10 Building Blocks of Advanced Primary Care by Bodenheimer, et al. Each building block concept has one or more activities that practices must achieve and maintain to demonstrate proficiency in that concept. These activities are listed across the columns headed Activity A, Activity B, etc. Some conceptual activities may require smaller, more mediate steps to build up to the conceptual activity. For example, the activity "Use shared decision-making to improve patient and family engagement" may require the practice to first develop shared decision-making practice transformation related changes and progress. SIM does not require that practices achieve all the milestone activities and steps by a certain time. Practices will be supported to work through the milestones at their own pace, choosing which milestones to focus on based on their local priorities and resources.

The sequence of the building blocks matters (i.e., population management preempts engagement). In general, blocks 1-4 are considered foundational, blocks 5-9 intermediate, and block 10 advanced. Activities within the "foundational" concepts to be the focus of beginning transformation work done by the practices and supported by SIM practice transformation resources and the intermediate and advanced concepts to be the focus once foundational concepts are in place.

Building Block Number	Building Block Description	Milestones			
		Activity A	Activity B	Activity C	Activity D
1	Engaged Leadership	Step 1 Practice completes all SIM practice and practice member assessments based on SIM program office timelines.	Practice regularly receives training on continuum of BH services and advanced BH integration strategies. SIM bi-directional health home champions receive training on continuum of primary care strategies.	Practice completes an annual budget or forecast with projected new SIM revenue flow and plan for anticipated practice expenses associated with practice redesign and integration activities.	Practice engages and cooperates with ongoing evaluation and technical assistance deliverables as defined by SIM Program Office.
		Step 2 Practice completes and submits baseline assessment to determine data capacity.	Practice trains 50% of staff in improvement methods and tools and forms Q team that meets regularly.	Practice selects the QIM group that best aligns to their patient population and transformation priorities.	At least quarterly, use data plus benchmark reports to inform continuous quality improvement on at least three clinical quality measures (CQMs).
		Step 3 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice incorporates regular improvement methodology to execute change ideas in a rapid cycle. Document a plan-do-study-act (PDSA) quality improvement cycle of small scale tests of change in the practice setting.	Practice uses automated data extraction through HIE to supply data for SIM QIM reporting.	
2	Data Driven Improvement Using Computer-Based Technology	Step 1 Practice documents strategy to achieve and maintain engagement to provider and care teams.	Practice periodically reviews attribution lists provided by payers and works with payer(s) to improve 70% concordance between internally empowered patients and payer attribution lists.		
		Step 2 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following team based care strategies: i. Daily team huddles to plan for patient visits ii. Collaborative care planning sessions iii. Standing orders	Demonstrate that individualized patient treatment plans that include both physical and behavioral health goals of care are accessible in the practice's EHR.	Participates in SIM bi-annual Learning Collaboratives. Serve as peer presenter at Learning Collaboratives, when requested.
		Step 3 Practice periodically (baseline and at least annually) reviews assessment of distribution of patient care tasks by role.	Practice implements at least two of the following team based care strategies: i. Daily team huddles to plan for patient visits ii. Collaborative care planning sessions iii. Standing orders		
3	Empowerment	Step 1 Practice documents strategy to achieve and maintain engagement to provider and care teams.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
		Step 2 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least two of the following team based care strategies: i. Daily team huddles to plan for patient visits ii. Collaborative care planning sessions iii. Standing orders		
		Step 3 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
4	Team-Based Care	Step 1 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
		Step 2 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least two of the following team based care strategies: i. Daily team huddles to plan for patient visits ii. Collaborative care planning sessions iii. Standing orders		
		Step 3 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
5	Patient-Team Partnership	Step 1 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
		Step 2 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least two of the following team based care strategies: i. Daily team huddles to plan for patient visits ii. Collaborative care planning sessions iii. Standing orders		
		Step 3 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
6	Population Management - Includes risk stratification, screenings, and care management activities.	Step 1 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		
		Step 2 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least two of the following team based care strategies: i. Daily team huddles to plan for patient visits ii. Collaborative care planning sessions iii. Standing orders		
		Step 3 Practice starts to capture and analyze population, disease specific, and relevant quality measures for utilization, billing data and tests ordered from their registry; practice management or EHR system to drive clinical practice improvement.	Practice implements at least one of the following health conditions, decisions or tests as component of shared decision-making, one of which in primary care must be related to BH and in QIMC must be related to physical health: i. Regular patient and family surveys at least quarterly. ii. Patient and family advisory council that meets at least quarterly.		

		Step 2	Establish and track metric for percent assignment of risk status and proportion of population in each risk category.	Implement two or more of the following three specific care management strategies for patients in higher risk cohorts (beginning with those at highest risk): 1. Coordination of BH services obtained outside of practice (originally) 2. Self-management support for at least 3 high-risk conditions including one BH condition; 3. Medication management and review.	Measure and report reach of BH screening and treatment activities in practice.	Practice uses the two registry systems to identify and proactively outreach to patients with gaps in care and/or not achieving guideline-based treatment goals.
7	Continuity of Care	Step 3	Continue to risk stratify all patients, achieving risk stratification of at least 75% of unpenalized patients.	80% of highest risk patients receiving care management services have an individualized patient treatment plan that includes both physical and behavioral health goals of care are accessible in the practice's EHR		Practice is able to show sustained improvement in the care of the two subpopulations.
		Step 1	Track continuity with primary care provider and/or care team.			
8	Prompt Access to Care	Step 1	Provide and attest to 24 hour, 7 days a week patient access to a practice representative that has access to practice's medical record for patient advice and to inform care by other professionals, including BH records if a BH professional is fully integrated in practice.	Enhance access by implementing at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment for a timely response.		
9	Comprehensiveness and Care Coordination	Step 1	Detail where patients access BH services outside of primary care practices. For 3M Bi-directional health services, detail where patients access primary care services outside of the health home.	Expect care compact/collaborative agreements with at least two groups of high-volume specialists in relevant specialties to improve patient care coordination for which primary care must be a BH provider group.	Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a medical neighborhood map and identifying a medical neighborhood impact and goals improvement in one of the following areas: a. Identification of ED visit in timely fashion. b. Practice medication reconciliation process completed within 72 hours of hospital or NICU discharge. c. Identification of admission and clinical information exchange at the time of admission. d. Identification of discharge, clinical information exchange, and care transition management at hospital and NICU discharge. e. Information exchange between primary care and specialty care related to referrals to specialty care.	
		Step 2	Track time from referral to intake for BH services with written protocol for patients not seen in reasonable amount of time, as defined by practice.	Practice reports defined improvements in care coordination and processes enabled through exchange of essential health information to eliminate waste and decrease costs.	Select one of the two options below, building on your earlier activities: • Contact at least 75% of patients or their families with ED visits within one week. • Contact at least 75% of patients or their families who are hospitalized in target hospitals or NICUs, within 72 hours.	
10	Integration and compensation reform	Step 1	Practice leadership receives education on implementing models of advanced access to BH services that includes financial, and operational considerations of the different options.	Practice accepts non-fee for service payments.	Practice engages at least one public health or community organization to make improvements in a mutual population health goal.	
		Step 2	Practice attests to practice and system support for advanced access to BH integration services, either onsite or remote, for at least three years and demonstrates support through written policies and procedures to create a culture integrated, team-based care.	Practice receives the majority of its financing through value based payments.		
		Step 3	Demonstrate advanced access to BH services practices: - Real-time and preplanned direct patient interaction for diagnostic support, crisis management, and coordination of ongoing treatment plan - Preplanned co-consultation with BH provider, primary care provider and patients/families - Real-time and synchronous consultation with primary care team members - Ongoing practice support to develop workflows and practices systems necessary for integrated models of care.			

## Appendix B - Colorado SIM Practice Reporting Overview Table

Assessment Tools	Purpose	Who Fills it Out	Responsible for Reporting	Timing	Expected Time to Complete (Minutes)
<b>Medical Home Practice Monitor</b>	Practice self-assessment of level of implementation of core aspects of advanced primary care	Practice Team led by PF	Practice Champion	Baseline & every 6 months	60
<b>IPAT</b>	Assesses current methods BHI along levels of coordination, co-location and integration	Practice Champion	Practice Champion	Baseline & annually	10
<b>Clinician and Staff Experience Survey</b>	Individual provider and staff survey that assesses two subscales - Clinician and Staff Experience and Burnout	All members of Practice	Each practice member	Baseline & annually	15
<b>SIM Milestone Activity Inventory</b>	Assesses practice's current implementation of SIM milestone activities, helps identify gaps and prioritizes practice's next steps	Practice Team led by PF	Practice Team submits draft, PF submits final	Baseline & every 6 months	60
<b>Data Quality Assessment</b>	Assesses practice's current state of data quality including accuracy of data element capture, validity of CQM reports and desired next steps for HIT	Practice HIT Champion led by CHITA	CHITA	Baseline & every 6 months	60
<b>Practice Improvement Plan</b>	SMART goals related to practice transformation as it relates to milestone activities; Can be done at same time as inventory	Practice Team led by PF	PF	Baseline & every 6 months	15
<b>Clinical Quality Measures</b>	Track patient and process outcomes achieved by practices	Practice Champion	Practice Champion	Every calendar quarter starting Q2 2016	Variable

*PF: practice facilitator. CHITA: clinical health information technology advisor. HIT: health information technology.*

Appendix C - SIM Cohort 1 Clinical Quality Measures Reporting Summary

**Colorado SIM Cohort 1  
Clinical Quality Measure Reporting Summary**

Year One Reporting Timeline			
Q1 (2/1/16 - 3/31/16) “Test Period”	Q2 (4/1/16 - 6/30/16) Report 3 measures	Q3 (7/1/16 - 9/30/16) Report 6 measures*	Q4 (10/1/16 - 12/31/16) Report 6 measures*
Reporting deadline: 4/30/16	Reporting deadline: 7/31/16	Reporting deadline: 10/31/16	Reporting deadline: 1/31/17

*\*Core measures should be prioritized before reporting additional measures. Core measures are shaded in green below.*

Year Two Reporting Timeline				
Q1 (1/1/17 - 3/31/17) Report all required measures according to patient population	Q2 (4/1/17 - 6/30/17) Report all required measures according to patient population	Q3 (7/1/17 - 9/30/17) Report all required measures according to patient population	Q4 (10/1/17 - 12/31/17) Report all required measures according to patient population	Q+** (1/1/18 - 3/31/18) Report all required measures according to patient population
Reporting deadline: 4/30/17	Reporting deadline: 7/31/17	Reporting deadline: 10/31/17	Reporting deadline: 1/31/18	Reporting deadline: 4/30/18

*\*\*Q+ = Final reporting period. While practice facilitation support ends January 31st 2017, practices will be asked to submit data for Q1 2017.*

### Adult Only Practices

The following two measures are reported through claims data automatically.

Measure	Citation
Breast Cancer Screening	NQF 0031
Colorectal Screening	NQF 0034

### Year 1

Q1 “Test Period”: Practices report what they can.

Q2: Practices report on 3 measures from table below.

Measure Condition	Citation
Flu	NQF 0041
Asthma	NQF 0036
Obesity	NQF 0421
Depression Screening	NQF 0418 Adolescents & Adults <b>OR</b> NQF 1401 Maternal Depression Screening
SUD Screening	NQF Composite 2597

Q3 & Q4: Report previous 3 measures plus additional 3 for a total of 6 measures. Must include 5 from core measure set (indicated in green), plus 1 additional.

Measure Condition	Citation
Flu	NQF 0041
Asthma	NQF 0036
Obesity	NQF 0421
Depression Screening	NQF 0418 Adolescents & Adults <b>OR</b> NQF 1401 Maternal Depression Screening
SUD Screening	NQF Composite 2597
Anxiety	GAD-7
Hypertension	NQF 0018

Diabetes: A1C poor control	NQF 0059
Diabetes: Blood pressure control	NQF 0061
Safety: Falls	NQF 0101

## Year 2

Q1, Q2, Q3, Q4, Q+: Practices must report on all of the following measures.

Measure Condition	Citation
Flu	NQF 0041
Asthma	NQF 0036
Obesity	NQF 0421
Depression Screening	NQF 0418 Adolescents & Adults <b>OR</b> NQF 1401 Maternal Depression Screening
SUD Screening	NQF Composite 2597
Anxiety	GAD-7
Hypertension	NQF 0018
Diabetes: A1C poor control	NQF 0059
Diabetes: Blood pressure management	NQF 0061
Safety: Falls	NQF 0101

## ***Pediatric Only Practices***

### Year 1

Q1 “Test period”: Practices report what they can.

Q2: Practices choose 3 measures from the table below.

Measure Condition	Citation
Flu	NQF 0041
Asthma	NQF 0036
Obesity	NQF 0024
Depression Screening	NQF 0418

Maternal Depression screening	NQF 1401
Developmental Screening	NQF 1448

**Q3 & Q4:** Report previous 3 measures plus additional 3 for a total of 6 measures.

Measure Condition	Citation
Flu	NQF 0041
Asthma	NQF 0036
Obesity	NQF 0024
Depression Screening	NQF 0418
Maternal Depression Screening	NQF 1401
Developmental Screening	NQF 1448

## Year 2

**Q1, Q2, Q3, Q4, Q+:** Practices must report all of the following measures.

Measure Condition	Citation
Flu	NQF 0041
Asthma	NQF 0036
Obesity	NQF 0024
Depression Screening	NQF 0418
Maternal Depression Screening	NQF 1401
Developmental Screening	NQF 1448

## ***Mixed Adult & Pediatric Practices\** Year 1 & Year 2**

Measures reported through claims data automatically.

Measure	Citation
Breast Cancer Screening	NQF 0031
Colorectal Screening	NQF 0034

\* In addition to these claims-based measures, practices will choose to follow pediatric only OR adult only reporting requirements. Practices are welcome to submit additional measures from a different measure group, but this is optional.

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