PRACTICE INNOVATION PROGRAM COLORADO
INNOVATION SUPPORT PROJECT

Innovation Support Program
Building Blocks Milestones

Building Blocks	Goal(s) for Building Block	Phase 1 Milestones	Phase 2 Milestones	Phase 3 Milestones
1. Leadership	Practice leadership supports and engages in quality improvement and change management	**1.1.1** Practice leadership sets practice-wide expectation for evaluating and improving clinical and operational processes and outcomes.	**1.2.1** Practice leadership allocates appropriate resources (including time for appropriate QI team membership) to ensure continuous quality improvement	**1.3.1** Practice leadership develops and implements a process to recognize and reward clinic level quality improvement initiatives.
2. Data Driven Quality Improvement (QI)	Practice extracts and uses clinical quality measure (CQM) data and sound QI methods to improve care.	**2.1.1** Practice develops quality improvement (QI) team and meets monthly.	**2.2 .1** Practice develops processes for providing performance feedback to providers at least quarterly, including CQM, cost, and utilization data.	**2.3.1** Practice evaluates its quality improvement process including clinician and staff engagement and the improvements attained and implements any indicated improvements.
		2.1.2 Practice sets quality metric goals using benchmarks and reviews performance on internally validated CQMs at least quarterly.	**2.2.2** Practice uses organized QI approach to meet quality measure goal/benchmark for at least one CQM.	**2.3.2** Practice meets quality measure goal/benchmark for at least three CQMs.
3. Empanelment	Practice manages panels to optimize access, continuity and business operations.	**3.1.1** Practice designs and implements process for validating primary care provider and/or care team assignments with patients	**3.2.1** Practice has assessed patient panel and assigned primary care providers and/or care teams to 90% of patient population.	**3.3.1** Practice actively manages acceptance of new patients based on chosen panel size to optimize access, continuity and business operations.
			3.2.2 Practice reviews and attempts to reconcile payer attribution lists on a quarterly basis.	
4. Team based care	Practice care team uses shared operations, workflows and protocols to facilitate collaboration and to improve quality and utilization metrics.	**4.1.1** Practice develops written job descriptions, including clear roles and responsibilities	**4.2.1** Practice reviews roles and responsibilities for team-based care activities to ensure accountability for assigned tasks.	**4.3.1** Practice develops a system to recognize and reward team members for innovation, contribution to organizational goals, and/or increasing their team-based care responsibilities
		4.1.2 Practice identifies and implements a team-based care strategy to improve communication (team huddle, debriefs, collaborative care planning)	**4.2.2** Practice identifies and implements two team-based care strategies to improve communication (team huddle, debriefs, collaborative care planning)	
		4.1.3 Practices assesses teamwork and team experience using a standardized tool, reviews results, and prioritizes area(s) for improvement.	**4.2.3** Practice uses QI team to develop and implement a plan for improving prioritized area(s).	**4.3.3** Practice re-assesses teamwork and team experience and reviews trends to prioritize additional area(s) for improvement.
			4.2.4 Practice develops and provides comprehensive orientation and onboarding support to all new staff and ongoing professional development for all staff	**4.3.4** Practice institutes formal training or another process to improve the way its team works together, such as good communication, role clarity, respectful relationships, mutual trust, inclusivity, and shared goals

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5. Patient and family engagement	Practice routinely uses evidence based shared decision aids and self-management support tools.	**5.1.1** Practice adopts at least one evidence-based decision aid or self-management support tool for a condition appropriate for their patient population	**5.2.1** Practice tracks use of their prioritized decision aid or self-management support tool and establishes a protocol and workflow to increase its use	**5.3.1** Practice adopts at least two decision aids and/or self-management support tools, tracks their use, and establishes protocols and workflows to increase their use
	Practice has established mechanisms for patients to provide input and feedback, including on transformation activities and progress.	**5.1.2** Practice convenes a patient and family advisory council (PFAC) at least once and develop plans for how to integrate recommendations into care and quality improvement activities as appropriate.	**5.2.2** Practice convenes a PFAC at least quarterly and integrates recommendations into care and quality improvement activities as appropriate	**5.3.2** Practice establishes mechanisms to refresh PFAC membership when necessary and better integrate feedback into quality improvement activities.
		5.1.3 Practice implements a patient experience survey and uses data to assess their delivery of primary care services as well as patient satisfaction with care.	**5.2.3** Practice reviews data from practice experience survey at least quarterly to identify areas for focus as part of their quality improvement process.	
6. Population Management	Practice uses population-level data to manage care gaps and develop and implement care management plans (including behavioral health) for targeted high-risk patients and families.	**6.1.1** Practice implements a risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: Step 1. Use an algorithm based on defined diagnoses, claims, or other electronic data allowing population-level stratification; and Step 2. Add the care team's perception of risk to adjust the risk stratification of patients, as needed.	**6.2.1** Practice provides episodic and longitudinal care management to identified high risk population likely to benefit from intensive care management.	**6.3.1** Practice has a documented care plan for 90% of its high risk patients and families, with the care plan embedded in the EHR.
		6.1.2 Practice identifies strategy to identify care gaps (e.g. EHR prompts, patient registry, data aggregation tool)	**6.2.2** Practice implements workflow for improving proactive care gap management and tracks specific outcomes.	**6.3.2** Practice assesses the impact of care gap management on outcomes and need for improvement in the process.

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7. Continuity of Care	Practice optimizes continuity of care for empaneled patients while preserving access	**7.1.1** Practice measures and reviews continuity of care for empaneled patients by primary care providers and/or care teams	**7.2.1** Practice implements one strategy that improves continuity for practitioners and care team(s)	**7.3.1** Practice re-assesses continuity of care and determines if further intervention is needed to improve continuity while balancing the need for prompt access to care.
8. Access	Practice provides prompt access to care, including behavioral health care, using traditional methods and new technologies.	**8.1.1** Practice assesses access to primary care services for its patients through availability of appointments and through patient experience survey.	**8.2.1** Practice adopts extended hours, same day appointments, patient portal, or other methods to improve access and then re-assesses for any problem areas.	
		8.1.2 Practice representative with EHR access available 24 hours, 7 days per week that includes behavioral health information		
		8.1.3 Practice assesses referral patterns and pathways and prioritizes high volume specialties with poor access for intervention.	**8.2.3** Practice establishes collaborative agreements with specialty groups or adopts new technology (such as e-consults, virtual visits, ECHO) to improve patient access to specialty services.	**8.3.3** Practice assesses the impact of the collaborative agreements and/or new technology on patient access to specialty services and determines any next steps for further improvement.
9. Comprehensiveness and Care Coordination	Practice provides comprehensive primary care services, including behavioral health.	**9.1.1** Practice assesses the services it provides to its patients and identifies key services that could be added to improve comprehensiveness of care, including for behavioral health.	**9.2.1** Practice assesses the impact of any added services on quality and/or cost of care	
		9.1.2 Practice develops a vision for behavioral health integration and chooses a strategy (such as full integration, virtual integration, collaborative care model) to improve comprehensiveness of behavioral health services.	**9.2.2** Depending on chosen strategy, practice 1) hires and onboards or contracts for an onsite behavioral health professional, 2) contracts with virtual behavioral health service, 3) contracts for collaborative care model support, or 4) otherwise arranges for engaging the appropriate behavioral health workforce.	**9.3.2** Practices implements protocols for identification and care management for high risk behavioral health populations.
		9.1.3 Practice develops a plan to systematically measure and track patient behavioral health outcomes related to at least one of the following conditions: depression, obesity, or substance use disorder.	9.2.3 Practice systematically measures and tracks patient behavioral health outcomes related to at least one of the following conditions: depression, obesity, or substance use disorder.	9.3.3 Practice implements a plan to systematically measure and track patient behavioral health outcomes related to a second of the following conditions: depression, obesity, or substance use disorder.

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		9.1.4 Practice performs assessment of referral pathways and available after-hours support for behavioral health, working with RHCs when possible.	**9.2.4** Practice establishes a collaborative agreement with at least one community behavioral health provider.	**9.3.4** Practice develops and implements process for bi-directional data sharing with at least one community behavioral health provider.
	Practice coordinates care with hospitals, EDs, and high volume specialists.	**9.1.5** Practice identifies data sources and technology needed for bi-directional data sharing with facilities responsible for the majority of their patients' hospitalizations and ED visits	**9.2.5** Practice implements a process to contact at least 75% of patients who are hospitalized in target hospital(s) within three business days after discharge, including medication reconciliation.	**9.3.5** Practice implements a process to contact at least 75% of patients with ED visits within three business days.
		9.1.6 Practice establishes a collaborative agreement with at least one behavioral health group or other high cost and/or high volume specialty group.	**9.2.6** Practice develops collaborative care agreements with at least two other high cost and/or high-volume specialty groups.	**9.3.6** Practice assesses the impact of the collaborative care agreements on access, coordination of care, and/or cost of care and determines need for revision of existing agreements and/or development of new agreements.
10. Value based contracting	Practice succeeds in their value based contracts by reducing total cost of care while improving quality for their patients.	**10.1.1** Practice considers mechanisms to maximize benefit of participation in alternative and performance payment arrangements	**10.2.1** Practice evaluates impact of value-based payment agreements on financial stability of practice, quality of care provided, and/or clinician and staff satisfaction.	**10.3.1** Practice develops value proposition and uses it to engage payers in value-based payment discussions.
		10.1.2 Practice identifies available cost of care reports that they can use to identify and manage high cost areas.	**10.2.2** Practice incorporates management of cost of care into their quality improvement process, including selecting strategies to reduce costs.	**10.3.2** Practice demonstrates improvement on at least one cost or utilization metric.
		10.1.3 Practice completes an annual budget that includes revenue and planned expenses for value-based revenue.	**10.2.3** Practice monitors and adjusts budget for value-based revenue as necessary.	**10.3.3** Practice shares financial data transparently with staff and providers and develops their capabilities in understanding the organization's finances and in using business practices and tools

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Optional Focus on Addressing Social Needs of Patients				
Optional Focus on Addressing Social Needs of Patients	Practice routinely assesses patients for social needs and links them to appropriate community resources.	**SN.1.1** Practice performs an assessment of the social needs of their patient population and prioritizes one or more conditions for focused work.	**SN.2.1** Practice develops and implements a process to screen for the prioritized social need and to connect those who screen positive and desire assistance to appropriate resources.	**SN.3.1** Practice develops and implements a process to screen for at least one additional social need and to connect those who screen positive and desire assistance to appropriate resources.
		SN.1.2 Practice performs an assessment of community resources, with Regional Health Connector support, to assist patients/families with social needs (such as food, housing, transportation).	**SN.2.2** Practice develops community partnerships to support patients who have the prioritized social needs.	**SN.3.2** Practice and community partners streamline information sharing to ensure patients' social needs are being addressed.
			SN.2.3 Work with community partners and regional health connectors to identify at least one social need in your clinical population that is difficult to address through currently available community resources.	**SN.3.3** Work with community partners and regional health connectors to advocate for expanded resources for previously identified underresourced social need.
Optional Focus on Substance Use Disorder				
Optional Focus on Substance Use Disorder	Practice systematically screens for substance use disorders and provides outpatient substance use disorder treatment for appropriate patients.	**SUD.1.1** Practice chooses a substance use screening tool (unhealthy alcohol use, opioid misuse, other drug dependence) and workflow for screening appropriate patients.	**SUD.2.1** Practice screens patients for risky substance use and provides interventions for patients with positive screens.	**SUD.3.1** Practice implements documented process (including standing orders and follow-up) for connecting patients/families with substance use issues to community resources.
			SUD.2.2 Practice trains teams and prescribers on evidence based treatments for alcohol use disorder or opioid use disorder.	**SUD.3.2** Practice provides outpatient medication assisted treatment for alcohol use disorder or opioid use disorder
Optional Focus on Telehealth				
Optional Focus on Telehealth	Practice effectively delivers and gets reimbursed for telehealth services, including behavioral health, delivered to patients.	**TH 1.1** The practice has determined services appropriate to provide through telehealth, including during emergencies such as the COVID-19 outbreak.	**TH 2.1** The practice has mapped the workflow for providing, supporting, and documenting telehealth services.	
		TH 1.2 Practice assesses their capacity to provide telehealth services and prioritizes one or more conditions for focused work	**TH 2.2** Practice identifies a platform to provide telehealth services to patients in prioritized focus areas.	**TH 3.2** Practice has a live platform and is providing telehealth visits to patients in prioritized focus areas.

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		TH 1.3 Practice can provide telehealth services to meet acute needs of patients in prioritized focus areas	**TH 2.3** Practice can provide telehealth services to meet prevention needs of patients in prioritized focus areas.	**TH 3.3** Practice can provide telehealth services to meet chronic needs of patients in prioritized focus areas.
		TH 1.4 Practice utilizes telehealth services for outreach to patients overdue for primary care services	**TH 2.4** The Practice utilizes telehealth services for outreach to patients overdue for chronic care services	**TH 3.4** The practice utilizes telehealth services for outreach to patients recently seen in the Emergency Department or recently discharged from the Hospital.
		TH 1.5 Practice identifies their current payers reimbursing for telehealth services.	**TH 2.5** Practice can bill and is getting reimbursed by Medicaid and Medicare for current telehealth visits with patients in prioritized focus areas	**TH 3.5** Practice can bill and is getting reimbursed by commercial insurance for current telehealth visits with patients in prioritized focus areas