Colorado State Innovation Model (SIM) Framework and Milestones

"Good standing" is defined as the following for each project year:

Practice Sites participating in SIM-Only:
- Project Year 1: Practice sites must achieve Year 1 milestones within building blocks: 1, 2, 3, 4, and 7.
- Project Year 2: Practice sites must achieve Year 2 milestones within building blocks: 1, 2, 3, 4, 7, and any two additional building blocks.

Practice Sites participating in SIM and CPC+:
- Project Year 1: Practice sites must achieve Year 1 milestones within building blocks: 1, 2, 3, 4, 7, 8, 9, and 10.
- Project Year 2: Practice sites must achieve Year 2 milestones within building blocks: 1, 2, 3, 4, 7, 8, 9, and 10.

BUILDING BLOCK	YEAR-1 MILESTONES	YEAR-2 MILESTONES	GOAL
1 Engaged leadership that supports integration and change	• Practice establishes agreement(s) with payer(s) covering at least 150 patients. • Practice has completed an annual budget. • Practice develops quality improvement (QI) team and meets monthly. • Practice leadership is present at meetings and clinical champion attends collaborative learning sessions. • Practice has vision for behavioral health integration, and has identified a pathway for behavioral health transformation signed by leadership.	• Leadership allocates appropriate resources to complete QI work. • Practice designs plan to evaluate impact of value-based payment agreements.	Practice establishes agreement(s) with payer organization(s) that cover at least 150 patients across payers, for value-based payment program(s) to support practice transformation under SIM.
2 Practice uses data to drive change	• Practice successfully submits CQMs quarterly. • Practice reviews data with practice facilitator (PF)/clinical health information technology advisor (CHITA) quarterly. • Practice begins using model for improvement and has identified opportunities for improvement using CQM data. • Practice begins using a data aggregation tool provided by SIM to review cost and utilization data.	• Practice reviews CQM data to inform rapid cycle improvement processes. • Practice develops processes for providing performance feedback to providers, including CQM, cost, and utilization data. • Practice conducts regular PDSA/QI activities on identified CQMs.	Practice uses EHR clinical quality measures to provide quarterly panel reports on all SIM measures not extracted through claims data; uses claims data provided through a data aggregation tool to inform QI processes.
3 Practice population is empaneled	• Practice has assessed patient panel and assigned primary care providers/care teams to 75% of patient population. • Practice reviews payer attribution lists quarterly. • Practice designs and implements process for validating primary care provider/care team assignment with patients.	• Practice maintains 75% empanelment of patients with provider/care teams. • Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage.	Practice has, and maintains, at least 75% of its patient population empaneled.

BUILDING BLOCK	YEAR-1 MILESTONES	YEAR-2 MILESTONES	GOAL
4 Practice provides team-based care	• Practice uses established tool to assess baseline team relationships. • Practice has written job descriptions, including clear roles and responsibilities. • Practice identifies and implements a team-based care strategy (team huddle, collaborative care planning).	• Practice reevaluates team relationship using tool from Year 1. • Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure). • Practice reviews roles/responsibilities for team-based care activities to ensure accountability for various tasks assigned.	The care team uses shared operations, workflows, and protocols to facilitate collaboration and consistently implements specific shared workflows rather than informal processes for at least three measures, including at least one behavioral health measure.
5 Practice has built partnership with patients	• Practice evaluates patient population to identify one preference-sensitive condition that is appropriate for decision aids or self-management support tools. • Practice identifies and selects evidence-based decision aids or self-management support tools for identified conditions. • Practice has established a Patient and Family Advisory Council (PFAC) and meets at least quarterly.	• Practice identifies patients and families eligible for selected decision aids or self-management support tools. • Practice implements decision aids or self-management support tools and establishes protocol and workflow for use. • Practice develops process for tracking and evaluating use of decision aids or self-management support tools. • Practice uses PFAC to evaluate care experience.	Practice has established use of evidence-based shared decision-making aids or self-management support tools for at least one, preference-sensitive condition, and tracks the use of these tools. Practice has established a PFAC to provide input and feedback on practice transformation activities and progress.
6 Practice risk stratifies and actively manages patient population using data	• Practice identifies, documents a risk stratification methodology. *(Recommended, but not required for pediatric practices)* • Practice identifies strategy to identify care gaps (e.g. patient registry, data aggregation tool) and prioritize high-risk patients/families.	• 75% of empaneled patients are risk-stratified. *(Recommended, but not required for pediatric practices)* • 75% of high-risk patients/families have a documented care plan. • Practice implements proactive care gap management and tracks outcomes. • Practice embeds care plan template in EHR.	Practice uses population-level data to manage care gaps, develop care management care plans and implement those plans for high-risk patients/ families.
7 Practice screens for behavioral health and substance use disorders and links primary care to behavioral health and social services	• Practice identifies behavioral health resources for patients/families, including support from SIM participating health plans and Regional Health Connectors (RHCs). • Practice identifies a screening tool for reporting on at least two behavioral health screening measures for SIM (depression, maternal depression, developmental disorders, obesity, and substance use disorders [i.e., unhealthy alcohol use, other drug dependence, and tobacco use]); screens 25% of patients. • Practice has documented process for connecting patients/families with behavioral health resources (from screening), including standing orders and or/protocols and follow-up.	• 50% of patients are screened for behavioral health conditions. • Practice performs an assessment of community resources, with Regional Health Connector support when possible, to assist patients/families with social needs (such as food, housing, transportation). • 50% of patients identified with behavioral health need are connected to resource.	Practice screens at least 90% of appropriate patients/families for substance use disorder and/or other behavioral health needs, and includes behavioral health and community services as part of care management strategies.

BUILDING BLOCK	YEAR-1 MILESTONES	YEAR-2 MILESTONES	GOAL
8 Practice provides prompt access to care, including behavioral healthcare	• Practice has representative with EHR access available 24 hours, 7 days per week. • Practice performs an assessment of referral pathways and available after-hours support for behavioral health, working with RHCs when possible. • Practice identifies data sources and technology necessary for bi-directional data sharing.	• Practice has established a collaborative agreement with at least one behavioral health provider. • Practice develops plan for bi-directional data sharing with behavioral health provider.	Practice, at a minimum, has established collaborative care management agreements with behavioral health providers in the community and members of the care team can articulate how to use those agreements. Practice has ability to share clinical data based on collaborative care management agreements with behavioral health providers bi-directionally within 7 days.
9 Practice provides comprehensive care coordination for primary/behavioral healthcare	• Practice can identify total cost of care for patient panel, and subset of patients with behavioral health conditions. • Practice identifies and implements policy and procedures that include timely follow-up for emergency department (ED) and hospital admissions.	• Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation. • Practice identifies cost drivers for patients with behavioral health condition(s) and incorporates in QI processes. • Practice creates and reports a measurement to assess impact and guide improvement on at least one of the following: 1. Notification of ED visit in a timely fashion 2. Medication reconciliation process completed within 72 hours 3. Notification of admission and clinical information exchange at the time of admission 4. Information exchange between primary care and specialty care related to referrals	Practice has reduced total cost of care while maintaining or improving quality of care for patients, including those with depression and substance use disorders, compared with non-SIM practices.
10 Practice has fully integrated behavioral healthcare to provide whole-person care	• Practice uses referral pathway identified for behavioral health needs (including available after-hours support and a representative with EHR access available 24 hours, 7 days per week). • Practice develops a plan to systematically measure and track patient behavioral health outcomes. • Practice develops care plans that include patient actions to manage behavioral health conditions.	• Practice systematically measures and tracks patient behavioral health outcomes. • Practice documents and implements protocols to identify and manage care for high-risk behavioral health populations. • Practice identifies and implements at least two opportunities to adjust its protocols to improve behavioral health status of patients. • Practice demonstrates advanced access to behavioral health services.	Patient behavioral health outcomes are systematically measured over time and treatment is adjusted as needed, as measured by outreach, registry and other information readily available for purpose of monitoring and adjustment.