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Practice Milestones for Feedback

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 labeled Activity A, Activity B, etc. Some complicated activities may require smaller, intermediate steps to build up to the more complex, rigorous activities. Breaking down these complex activities into smaller, intermediate steps (Step 1, Step 2, etc.) will allow practices the ability to achieve milestones at their own pace and to show timely incremental progress towards implementing difficult practice transformation related changes and progress.

The sequence of the building blocks matters (i.e. population management presupposes empanelment). In general, blocks 1-4 are considered foundational, blocks 5-9 intermediate, and block 10 advanced. We will expect the 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				
		Steps	*Activity A*	*Activity B*	*Activity C*	*Activity D*
1	**Engaged Leadership**	*Step 1*	QI team completes comprehensive primary care monitor (a practice assessment tool) every six months.	Primary care practice attends training on continuum of BH services and advanced BH integration strategies. Colorado Mental Health Center (CMHC) receives 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.	Fully engage and cooperate with ongoing evaluation and technical assistance deliverables as defined by SIM Program Office.
2	**Data Driven Improvement Using Computer-Based Technology**	*Step 1*	Practice completes and submits baseline assessment to determine data capacity.	Practice trains 50% of staff in improvement methods and tools and forms QI team that meets regularly.	Practices selects the CQM group that best aligns to their patient population and transformation priorities.	At least quarterly, use data hub benchmark reports to inform continuous quality improvement on at least three clinical quality measures (CQMs).
		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 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.	Practices will report on three of the core measures within six months of SIM engagement and all core measures within 12 months. Practices report at least three discretional measures within 18 months. Once started, reporting is to occur quarterly.	
		Step 3			Practice uses automated data extraction through HIE to supply data for SIM CQM reporting.	
3	**Empanelment**	*Step 1*	Practice documents strategy to achieve and maintain empanelment to provider and care teams.	Practice periodically reviews attribution lists provided by payers and works with payer(s) to reconcile discrepancies.		
		Step 2	Achieve and maintain 80% empanelment to provider and care teams.	Practice achieves 70% concordance between internally empaneled patients and payer attribution list.		
		Step 3	Achieve and maintain at least 95% empanelment to provider and care teams.			
4	**Team-Based Care**	*Step 1*	Practice periodically (baseline and at least annually) reviews assessment of distribution of patient care tasks by role.	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.	Participate in SIM bi-annual Learning Collaboratives. Serve as peer presenter at Learning Collaboratives when requested.
		Step 2	Practice better distributes workload throughout the team in ways that makes optimal use of team members' training and skill sets .	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		
5	**Patient-Team Partnership**	*Step 1*	Implement self-management support for at least three high risk conditions.	Assess and improve patient and family experience of care by selecting at least one of the following: a. Regular patient and family surveys at least quarterly. b. Patient and family advisory council that meets at least quarterly.	Develop communication(s) to patients, families, and the clinic about the specific changes your practice is implementing (e.g. a pamphlet or posters) including the efforts related to integrated care.	Implement shared decision making tools or aids in 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			Specify the changes to the practice that have occurred during each reporting period as a result of, or influenced by, practice survey/PFAC activities.	Track use of shared decision making aids using one of the following methods: 1. A metric tracking the proportion of patients and families eligible for the decision aid who receive the decision aid; OR 2. Quarterly counts of patients and families receiving individual aids.

6	**Population Management** *- Includes risk stratification, screening, and care management activities.*	***Step 1***	Indicate methodology used to assign risk status to every empaneled patient.	Provide care management to at least 80% of highest risk patients.	In primary care, attest that 90% of patients are screened for at least one BH condition for which the practice has a documented workflow to assist patients who screen positive.	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 BH condition or on preventive needs (i.e. well child checks, age appropriate screenings) or a chronic medical condition (i.e. diabetes, asthma).
		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 (required); 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.
		Step 3	Continue to risk stratify all patients, achieving risk stratification of at least 75% of empaneled patients.	80% of highest risk patients receiving care management services have an integrated patient treatment plan that includes both physical and behavioral health goals accessible in the primary care EHR.		Practice is able to show sustained improvement in the care of the care of the two subpopulations.
7	**Continuity of Care**	***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 practice. Detail where patients access primary care services outside of CMHC.	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 group.	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. a. Notification of ED visit in timely fashion. b. Practice medication reconciliation process completed within 72 hours of hospital or NICU discharge. c. Notification of admission and clinical information exchange at the time of admission. d. Notification 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: a. Contact at least 75% of patients with ED visits within one week. b. Contact at least 75% of patients who were hospitalized in target hospital(s), 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 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.			