SIM Milestone Activity Inventory Overview

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 HIT advisor tailor their support to the individual needs of the practice.

The process of completing the SIM Milestone Activity Inventory will be electronic 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 program office timelines.

Baseline 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			

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

12 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			

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 bi-directional 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 HIT advisor? (select all that apply)

- ☐ We have not interacted with our clinical HIT advisor 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 competed?

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

<u>Step 3</u>: 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)

<u>Building Block 3: Empanelment</u>

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)*

<u>Building Block 4: Team Based Care</u>

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?

- ☐ Provider (MD, DO, PA, NP)
- ☐ RN/LPN
- ☐ MA/CNA
- ☐ Care coordinator
- ☐ Behavioral Health Provider
- ☐ Pharmacist
- ☐ Front office/receptionist
- ☐ Office staff/medical records
- ☐ Other _____

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?
   - ☐ Provider (MD, DO, PA, NP)
   - ☐ RN/LPN
   - ☐ MA, CNA

- ☐ Care coordinator
- ☐ Behavioral Health Provider
- ☐ Pharmacist
- ☐ Front office/receptionist
- ☐ Office staff/medical records
- ☐ Patient and/or family
- ☐ Other

Standing orders and standardized protocols (if selected)

1. Practice has standing orders or standardized protocols for:
   - ☐ Diabetes labs and other orders
   - ☐ Symptom based tests (i.e. pregnancy tests, rapid strep tests, urine dipsticks)
   - ☐ ADHD
   - ☐ Preventative screening
   - ☐ Immunizations
   - ☐ Medication refills
   - ☐ Medication adjustments (i.e. insulin, blood pressure medications, anticoagulation)
   - ☐ Other (free text)
   - ☐ No standing orders are used

   Autoscore for standing orders: Red if "no standing orders are used"; Yellow 1-2 checked; Green 3+ checked

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

Autoscore 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.)

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

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 Learning Collaboratives. Serve as peer presenter at Learning Collaboratives when requested.

How often has a practice member participated as a presenter or panel member at a SIM bi-annual learning collaborative?

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 learning collaborative 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)

- ☐ ADHD
- ☐ Autism
- ☐ Pregnancy
- ☐ Early childhood care
- ☐ Hospital or NICU discharges
- ☐ Obesity
- ☐ Diabetes
- ☐ Hypertension
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Chronic pain
- ☐ Substance abuse disorders
- ☐ Other (free text)

Select the tactics your practice uses to support self-management across conditions. Select all that apply:

- ☐ Between visit care planning
- ☐ Health coaching at visits
- ☐ Health coaching between visits
- ☐ Agenda planning
- ☐ Identify, document and follow up on patient goals
- ☐ Peer-led support for self-management
- ☐ Group visits
- ☐ Evidence based counseling: check all that apply:
- ☐ Motivational Interviewing
- ☐ 5 As
- ☐ Reflective Listening
- ☐ Teach Back
- ☐ Other: (free text)
- ☐ 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?

- ☐ Therapeutic options in management of obesity
- ☐ Therapeutic options in management of acute sinusitis
- ☐ Therapeutic choices in management of asthma
- ☐ Behavioral and therapeutic choices for family planning
- ☐ Therapeutic choices in management of ADHD
- ☐ Diagnostic and therapeutic management of acute low back pain without high risk indicators
- ☐ Therapeutic options in management of insomnia
- ☐ Therapeutic options in management of chronic pain
- ☐ Therapeutic options in management of menopausal symptoms
- ☐ Therapeutic options in management of mild anxiety
- ☐ Therapeutic options in management of mild depression
- ☐ Therapeutic options in management of postpartum depression
- ☐ Therapeutic options in management of urinary incontinence
- ☐ Therapeutic options in management of functionally significant osteoarthritis of the hip or knee
- ☐ 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:

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

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

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

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

☐ 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 1 (name)
☐ Other 2 (name)
☐ Other 3 (name)

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)*

Autoscore 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 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.

- [ ] No other 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
- [ ] Diabetes
- [ ] Hypertension
- [ ] Asthma
- [ ] Congestive heart failure
- [ ] Well child checks
- [ ] Colon cancer screening
- [ ] Breast cancer screening
- [ ] Immunizations
- [ ] 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.

<u>Building Block 9: Comprehensiveness and Care Coordination</u>

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)

- ☐ We have not created a care compact or collaborative agreement with a specialty provider
- ☐ Allergy
- ☐ Anesthesiology
- ☐ Cardiology
- ☐ Dermatology
- ☐ Emergency Medicine/Emergency Department
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Surgery
- ☐ Hematology
- ☐ Hospital
- ☐ Infectious Disease
- ☐ Nephrology
- ☐ Neurology
- ☐ NICU
- ☐ Obstetrics/Gynecology
- ☐ Oncology
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Physical Medicine and Rehabilitation
- ☐ Physical Therapy
- ☐ PICU
- ☐ Podiatry
- ☐ Pulmonology
- ☐ Radiology & Imaging
- ☐ Rheumatology
- ☐ Urology
- ☐ Other (specify)
- ☐ 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?

☐ Local public health department
☐ State public health department
☐ Local health alliance
☐ Spiritual or religious group
☐ School (elementary, middle, high)
☐ School of higher education (i.e. community college, university)

- [ ] Community recreation center
- [ ] Fitness center
- [ ] Local business group or employer
- [ ] Philanthropy organization
- [ ] Other (describe)

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 HIT 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.