Colorado State Innovation Model (SIM) Implementation and Milestone Reporting Summary Guide for Primary Care and Bi-directional Health Home Milestone Activities

Revised for SIM Cohort 2, 2017
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Summary
The State of Colorado will receive up to $65 million 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 Comprehensive Primary Care Plus (CPC+). The SIM initiative adopts many high value primary care activities of CPC+ 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 (PTOs), Practice Facilitators (PFs), Clinical Health Information Technology Advisors (CHITAs), and Regional Health Connectors (RHCs). This guide provides a detailed description of the SIM Cohort 2 Milestones and recommendations on how to meet the objectives described in the milestones. There are a number of corresponding materials and resources, including online provider education modules developed by SIM, to help participants educate themselves as they undertake the work described in this Implementation Guide. These materials and resources that are integrated throughout this document are located within the Practice Innovation Resource Hub and can be found at http://resourcehub.practiceinnovationco.org.

On behalf of the entire support team, we welcome your participation in this critical endeavor and are excited to work with you to further enhance primary care by more closely integrating it with behavioral health.

Acknowledgements
The original SIM Implementation Guide, toolkit, and milestone activity inventory for Cohort 1 were developed by a large group of engaged stakeholders in the Practice Transformation Implementation Guide & Toolkit Development Committee. This document was built upon the hard work of the Committee and was updated to reflect changes in the modified SIM Framework and Milestones by Stephanie Gold, Stephanie Kirchner, and Kyle Knierim from the University of Colorado Practice Innovation Program and Marjie Harbrecht with MGHealthcare Insights, LLC. Technical editing and proofreading provided by Heather Stocker, Marlee Barton, and Allegra Bishop.

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Introduction

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

Health care in the US is changing. The Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA) are 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. 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 reimbursements 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 practices will need to develop new skills and processes to prepare for these changes. The SIM initiative will bring resources to practices to assist in the journey to improve the health of their patients, and succeed in future payment and care models.

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 healthcare to integrate care of behavioral health with physical health within primary care medical homes and medical homes based in community mental health centers.

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.

Providing more comprehensive care that integrates both physical and behavioral healthcare within one clinical care setting enhances whole-person 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 physical and behavioral care within the medical home setting. See the following section describing organizational frameworks for categories of enhanced collaboration between physical and behavioral health providers.

In order to be responsive to the needs and business realities of our many practices, SIM recognizes that not all practices will be able to develop models of fully integrated behavioral health, and for some a closely coordinated model with effective referral and follow up is the most appropriate strategy. Practices will be offered coaching, tools, and other resources that can help determine the right path to improve behavioral health care for their patients based upon their individual resources, interest, funding, and payer mix.

SIM Practice Transformation Milestones: Organizing Frameworks

The SIM practice transformation building blocks as outlined within the SIM Framework and Milestones document reflect common attributes of high-performing primary care. They are organized based on a well-recognized framework, Bodenheimer’s “10 Building Blocks of High-Performing Primary Care.” These building block concepts are consistent with themes articulated in other published frameworks including the Joint Principles of the Patient-Centered Medical Home (PCMH), 3 various medical home recognition standards, the Change Concepts for Practice Transformation, 4 University of Utah’s Care by Design, 5 and published research on practice transformation. 6,7 The Colorado Multi-Payer Collaborative, which supports SIM practices through alternative payment models, has slightly modified Bodenheimer’s original building blocks to adapt them to the SIM initiative’s more targeted goals and its focus on behavioral health.

**Building Block 1, Engaged leadership that supports integration and change:** 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. It also describes how to establish value-based payment agreements, how to introduce the practice to concepts of integrated behavioral health, how to create a budget that includes SIM related activities, and sets the stage for quality improvement (QI) work in Building Block 2.

**Building Block 2, Practice uses data to drive change:** focuses on the importance of data, the use of data to drive improvement in a practice, and 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 enhances competencies to access and understand their data, establish baseline data and use quality improvement methods to improve outcomes.

**Building Block 3, Practice population is empaneled:** assists the practice to understand 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, Practice provides 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, Practice has built partnership with patients:** 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; and how to establish a Patient and Family Advisory Council (PFAC) to obtain regular feedback. Each of these elements improves outcomes and the patient experience.

**Building Block 6, Practice risk stratifies and actively manages patient population using data:** helps the practice develop skills in population management including risk stratification, creation of care plans, and providing proactive care gap interventions. Each of these techniques add to the team’s ability to improve the outcomes for specific groups of patients.

**Building Block 7, Practice screens for behavioral health and substance use disorders and links primary care to behavioral health and social services:** focuses on screening for behavioral health conditions and connecting patients to behavioral health resources. It also includes assessing available resources in the community for social needs.

**Building Block 8, Practice provides prompt access to care, including behavioral healthcare:** involves creating collaborative agreements with behavioral health providers and plans for referral pathways and bi-directional data sharing. It further ensures a practice representative has 24/7 access to patient records; outcomes improve when patients receive care from a provider who has direct access to the patient’s current EHR.

**Building Block 9, Practice provides comprehensive care coordination for primary/behavioral healthcare:** focuses on strategies for improving coordination of care within the practice, with outside behavioral health providers, and with other institutions, including hospitals and emergency departments.
Building Block 10. *Practice has fully integrated behavioral healthcare to provide whole-person care:* focuses on care planning and protocols for high-risk behavioral health populations and tracking behavioral health outcomes.

The other framework used extensively throughout the SIM initiative and milestone activities is a model for conceptualizing the categories of collaboration between physical 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](https://www.samhsa.gov) and the [AHRQ Academy for Integrating Behavioral Health in Primary Care](https://www.ahrq.gov). Both organizations describe a continuum of integration between behavioral health and primary medical care.

There are three general forms of integration:

- **Coordinated Care** - behavioral health and medical providers practice in different locations but 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 provide traditional outpatient behavioral health and medical care separately but their offices are housed in the same location.

- **Integrated Care** - behavioral health and 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 clinical setting, and provide integrated care as a team.

Though this continuum depicts a linear path to integration, with standardized communication and improved co-management of patient care, coordinated and co-located arrangements also better support patients and improve access to behavioral health services. A more detailed version of the continuum of integrated care models can be found at the [SAMHSA-HRSA Center for Integrated Health Solutions](https://www.samhsa.gov) website. Definitions and information on the concepts of integrated behavioral health can be found in the [Lexicon for Behavioral Health and Primary Care Integration](https://www.ahrq.gov).

**General Philosophy of SIM**

Different patient populations will have different needs, and the focus of both 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 use. However, the whole continuum of care from prevention, health promotion, early identification and intervention 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 towards integrated care. The SIM practice transformation 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 to develop 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 tracks progress on all milestone activities, not all practices will have the time, capacity, or financing to complete all activities. The new SIM Framework and Milestones document that reflects the updated SIM practice transformation building blocks, was developed by the Colorado Multi-Payer Collaborative, and provides targets that are valued and expected by payers for practices to qualify for alternative payment models. 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 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), a Regional Health Connector (RHC), semi-annual Collaborative Learning Sessions (CLS), webinars and other training sessions, and the ability to apply for funding for innovative projects that advance the accomplishment of the SIM practice transformation building blocks outlined in the SIM Framework and Milestones.

The goal 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 participate in SIM, including family practices, pediatric practices, internal medicine practices, school based health centers, residency training programs, large healthcare systems and multi-site organizations, 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 adapt to support innovative approaches to accomplish its overarching goal of achieving the Triple Aim across settings.

Guiding Documents and Resources

The Colorado State Innovation Model (SIM) Implementation and Milestone Reporting Summary Guide for Primary Care and Bi-directional Health Home Milestone Activities, often referred to as the SIM Implementation Guide, provides SIM practices and the Practice Transformation Organizations (PTO’s) that support them with a framework and suggested action steps to operationalize the SIM Framework and Milestones (Appendix A). Used in parallel with the SIM Milestone Operational
Algorithm (Appendix D) and the SIM Phased Approach Practice Timeline (Appendix E), practices and PTO’s can plan and map practice level progress through SIM participation.

**Updates from the Cohort 1 Implementation Guide**

This Implementation Guide builds from the Cohort 1 SIM Implementation Guide and updates it to match the new SIM Framework and Milestones (Appendix A) updated for Cohort 2. Changes were made to the milestones to further enhance the focus on integrating behavioral health and primary care and to streamline them to create a clearer, structured timeline for progression. These changes were made in collaboration with the Colorado Multi-Payer Collaborative to ensure alignment between practice transformation work and the advanced payment models supporting them.

Changes to the Cohort 1 milestones include:

- Organization to match the timeline of expectations. The previous milestones were divided into lettered (A, B, C) activities with numbered steps for each activity; now the milestones are divided by year 1 and year 2 expectations. Many year 1 milestones involve preparing and developing infrastructure to start a new process with a corresponding year 2 milestone to fully implement and scale the process. While some practices may accomplish year 2 milestones in year 1, this provides a general guide for the advancement of the practices.
- Modification of the approach towards advanced primary care to have an increased focus on integrated behavioral health in line with the specific aims of the SIM initiative.
- Slight adjustments to requirements to align with the Comprehensive Primary Care Plus Initiative (CPC+).

In Cohort 2, in order to maintain “Good Standing” within the SIM initiative, practices will be required to achieve specific milestones within the practice transformation building blocks in both year 1 and year 2 as outlined in the SIM Framework and Milestones (Appendix A). Details and expectations of “Good Standing” are outlined in the SIM Milestone Attestation Checklist (Appendix F):

**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.
**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 goal of the building block, the work for the medical home described through milestone activities, and suggested “Action Items” to get practices started. Appendix A, the SIM Framework and Milestones document summarizes the milestone activities associated with each building block. As you read each of the Building Block sections within the SIM Implementation Guide it may be helpful to print Appendix A to use as a reference.

**Building Block 1: Engaged leadership that supports integration and change**

**Goal:** 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.

**Overview:**
To successfully drive improvement in quality and patient outcomes, it is critical that leaders respond to 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.

Implementing integrated behavioral health and primary care services along with the other 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, CHITAs and other SIM resources, can take steps to be ready for these new reimbursements.

**YEAR 1**

**BB1.Y1.1. Practice establishes agreement(s) with payer(s) covering at least 150 patients.**
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. Review the materials in the SIM Resource Hub that describe the types of non-fee-for-service payment methods, also called alternative payment models (APMs).
2. Identify the APMs that are available to your practice from various payers. List the types of APMs your practice is already paid by health plans and estimate what proportion of the
patient population is covered under these arrangements. If you have not yet received
communication from the payers in SIM that will be supporting your practice through APMs,
contact the SIM Office at gov_simgrant@state.co.us.

3. Select payer(s)/APM(s) to engage with and focus on for improvement that will cover at least
150 patients. Ideally, select one that rewards activities or outcomes that the practice will be
working on as part of SIM, supporting BH integration, 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 process 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.
Build this into QI work (see BB2).

6. Negotiate and finalize value-based agreement(s) with payer(s).

Practice Attestation Anchor:
Attest to value-based agreement(s) with one or more payers that cover at least 150 patients attributed
to the practice site. If not, provide reasons beyond the practice's control why this has not been
possible.

Practice Facilitator Attestation Methodology:
Confirm such an agreement or agreements exist.

BB1.Y1.2. Practice has completed an annual budget that includes SIM revenue and planned
expenses.
Perhaps the best indicator of future economic success is having and using a budget to plan and
evaluate financial performance. 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.

The practice budget serves as an annual financial plan to define the resources available to attain short
and long-term goals and compares actual performance to what was forecasted. Components to
creating an effective annual budget include:

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.

**Action Items**

2. Use a [budget template](#) that accounts for compensation expectations, volume estimates, operating expenses, and revenues.

**Practice Attestation Anchor**: Attest to the development of a current budget. If the practice has received alternative payments from payers, the budget should include those revenues and planned expenses to meet contract deliverables.

**Practice Facilitator Attestation Methodology**: PF confirms that a budget as described exists at whatever level is appropriate for the practice (practice level or system level). Details of the budget do not need to be reviewed.

**BB1.Y1.3. Practice develops a quality improvement (QI) team and meets monthly.**

Change in practice requires a reflective, action-oriented team to remain focused on established quality improvement goals. Formal clinical and administrative leaders as well as informal leaders from front and back office should meet regularly to inform tests of change and be responsive to practice level data.

**Action Items**:

1. Form a QI team with key staff members from each area of the practice.
2. Provide training on QI methods and tools for all involved staff.
3. Define responsibilities of each team member and identify a clinical champion. Include who will be responsible for validation, production, review, and communication of metrics. Identify staff member(s) who will lead and be familiar with the Shared Practice Learning and Improvement Tool (SPLIT) which will help facilitate practice performance reporting.
4. Schedule regular team meetings focusing on QI projects within the practice.
5. 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) Medical Home Practice Monitor (completed annually)
   c) IPAT (completed annually)
   d) Clinician and Staff Experience Survey (completed annually)
e) Milestone Attestation Checklist (updated every 6 months)
f) HIT Assessment (updated every 6 months)

The purpose of each of these assessment tools and additional details on their use can be found in Appendix B, SIM Assessments and Reporting Schedule, and can be accessed on the SIM Shared Practice Learning and Improvement Tool (SPLIT).

Practice Attestation Anchor:
Document at least monthly meetings through meeting agendas and/or minutes.

Practice Facilitator Attestation Methodology:
Confirm and document improvement team meetings in monthly field notes. Attest if, in your opinion, the practice has fully accomplished the milestone as described in the anchor statement.

BB1.Y1.4. Practice leadership team is present at meetings and clinical champion attends SIM Collaborative Learning Sessions.
Often the best solutions come from practices that have tested and implemented innovative ideas. SIM will host bi-annual Collaborative Learning Sessions (CLS) for SIM practices to share their successful ideas and learn from one another. 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 CLS.
2. Encourage other team members that will benefit from the supportive learning environment to attend the CLS.
3. Actively participate in learning events by suggesting topics you would like addressed or innovative ideas you would like to share on a panel or in a breakout presentation.

Practice Attestation Anchor:
Document through minutes of quality improvement team meetings.

Practice Facilitator Attestation Methodology:
Document in monthly field notes and attest if practice meets the milestone as described in the anchor statement.

BB1.Y1.5. Practice has vision for behavioral health integration, and has identified a pathway for behavioral health transformation that is signed by leadership.
SIM promotes a broad definition of behavioral health (BH) that encompasses mental health concerns, substance use 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 and developmental 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 to adopt fully integrated models of BHI. Each practice must determine what form is best for them.

SIM also supports community mental health centers implementing a bi-directional 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 bi-directional 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 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, SIM Assessments and Reporting Schedule for the list of Assessments and detailed information about each.
2. Identify the level of BH integration that the practice aspires to achieve according to SAMHSA and AHRQ levels of Collaboration/Integration (Coordinated, Co-Located, or Integrated).
3. Identify scope of practice/population needs, organizational supports, FTE needs, electronic health record sharing needs, and supervision needs to accomplish level of integration desired.
4. Create a written, signed vision statement including how your practice will approach BH integration.

**Practice Attestation Anchor:**

Produce documentation of a vision statement for behavioral health transformation that includes their selected pathway for behavioral health transformation. This can include such things as plans for full integration, improved coordination through collaborative care, use of telehealth, collaboration agreements with behavioral health entities, etc., as appropriate for the practice site.

**Practice Facilitator Attestation Methodology:**

Confirm that a vision statement exists that includes their planned pathway for behavioral health transformation. This should be documented and shared across the practice and with the PF/CHITA/RHC.
**YEAR 2**

**BB1.Y2.1. Leadership allocates appropriate resources to complete QI work.**
Time is a valuable resource in primary care, with time away from patient care often meaning time away from revenue generating opportunities. To succeed in sustainable change and improvement, leadership must recognize and protect time for teams to focus on quality improvement efforts and review data on a regular basis.

**Action Items:**
1. Determine the time and space requirements for ongoing QI meetings. Protect time for twice-monthly QI team meetings by blocking patient care responsibilities where necessary.
2. Consider what time and resources may be required for QI team work outside of regular meetings and budget for anticipated expenses.

**Practice Attestation Anchor:**
Document ongoing, regular (at least monthly) QI team meetings as in BB1.Y1.3 and show how resources have been allocated to complete QI work.

**Practice Facilitator Attestation Methodology:**
Confirm ongoing, regular QI team meetings are occurring and document this in monthly field notes. Attest if in PF opinion the practice has allocated sufficient resources for the QI work, including engagement of adequate practice site clinicians and staff in the process.

**BB1.Y2.2. Practice designs plan to evaluate impact of value-based payment agreements.**

**Action Item:**
1. Develop a plan to use value-based payment agreements to improve care, reduce costs, and improve satisfaction. When using additional revenues (i.e., to hire new staff, purchase new equipment, protect time for practice improvement activities), consider how to make these changes sustainable long-term, regardless of payment models available.

**Practice Attestation Anchor:**
Demonstrate how the practice uses and assesses the impact of value-based payments.

**Practice Facilitator Attestation Methodology:**
Confirm practice development and implementation of a plan. Attest if the practice site has a plan in place and has evaluated the impact of their value-based payments. Document if barriers have prevented value-based payment agreements from being developed.
Building Block 2: Practice uses data to drive change

Goal: 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.

Overview:
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 SIM 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 review the data, opening the door for conversation and accountability. See Appendix C for CQM Reporting Summary.

Additional data sources may include:
- Payer: cost/utilization reports, gaps in care reports, attribution lists
- Health Information Exchange (HIE): utilization; notifications of admissions, discharges, and transfers (ADT); 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 (ED) utilization

These data will be reviewed during regular quality improvement (QI) team meetings, and will serve as a foundational component in selection of measures that best align to your patient population and transformation priorities.

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

YEAR 1

BB2.Y1.1. Practice successfully submits CQMs quarterly.
SIM CQM reporting requirements are detailed in Appendix C. In general, SIM will use a rolling 12-month reporting period for CQMs. Reporting of numerators and denominators for CQMs at a practice OR provider level will be expected within 1 month from the end of the calendar quarter. Collection and performance reporting of CQMs will be managed within SPLIT.

Action Items:
1. Review the SIM Clinical Quality Measures Reporting Summary (See Appendix C) and reporting requirements.
2. Choose either the Pediatric or Adult/Family CQM group based on the patient population your practice serves.
3. 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.
4. Submit numerators and denominators within one month of the end of each calendar quarter.

**Practice Attestation Anchor:**
Selected group of CQMs submitted quarterly to SIM.

**Practice Facilitator Attestation Methodology:**
This will be monitored through submission of CQMs through the Shared Practice Learning and Improvement Tool (SPLIT).

**BB2.Y1.2. Practice reviews data with PF/CHITA quarterly.**

**Action Items:**
1. Complete the necessary practice agreements with the University of Colorado and complete the PTO matching documents included in SIM Practice Participation Packet to partner with 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 within 30 days of match to PTO or project kick-off.
3. Complete and review the results of your practice assessments with your PF and CHITA, using them to identify gaps and prioritize next steps. CQM run charts are updated daily and can be accessed through your SPLIT login at [https://split.practiceinnovationco.org](https://split.practiceinnovationco.org).
4. Work with your CHITA to identify current reports available from the EHR, Health Information Exchange, or other data sources.
5. Set regularly scheduled meetings (at minimum quarterly) with your PF and CHITA to review your CQM reports and other related data.
6. Complete the HIT Assessment with the help of your CHITA at baseline and update it every 6 months.
7. Create a development plan for CQMs currently not available to your practice, as necessary, prioritizing the core SIM measures and CQMs related to your practice’s QI activities.

**Practice Attestation Anchor:**
Show evidence that clinical quality measures were reviewed with a PF or CHITA at least every 3 months. This could include documentation in improvement team agendas or meeting minutes.

**Practice Facilitator Attestation Methodology:**
Document in PF and CHITA monthly field notes and attest if practice meets the milestone as described in the anchor statement.
BB2.Y1.3 Practice begins using model for improvement and has identified opportunities for improvement using CQM data.

The model for improvement, developed by Associates in Process Improvement, is a straightforward and pragmatic tool for accelerating process change. The model consists of 3 fundamental questions and the Plan-Do-Study-Act cycle to test changes. The 3 fundamental questions are:

1. What are we trying to accomplish? Aims should be time-specific, measurable, and define the target population.
2. How will we know that a change is an improvement? Measures to examine may be considered in a few areas: outcome measures, how the change impacts patients or other stakeholders; process measures, if the steps towards change are implemented as planned; and balancing measures, if changes are causing problems in other parts of the system.
3. What change(s) can we make that will result in improvement?

The Plan-Do-Study-Act cycle refers to an approach of planning the change, trying it, examining the results, and acting based on what is learned.

Action Items:

1. If you or your team are starting from scratch, review the e-Learning Module on Quality Improvement.
2. Determine 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. Review data, including CQM data you submitted to SIM, at QI meetings.
4. Work with your PF/CHITA to select and use a quality improvement tool(s) such as process mapping, brainstorming, and/or fishbone diagrams.
5. Develop and document a Plan-Do-Study-Act (PDSA) for rapid cycle improvement.

Practice Attestation Anchor:
Document through minutes of quality improvement team meetings.

Practice Facilitator Attestation Methodology:
Document in monthly field notes and attest if practice meets the milestone as described in the anchor statement.

BB2.Y1.4. Practice begins using a data aggregation tool provided by SIM to review cost and utilization data.

SIM will be rolling out tools for practices to review their cost and utilization trends and how they compare to others. Information will be shared with you as soon as these tools are available.
Action Items:
1. Work with your PF and CHITA to review cost and utilization data in data aggregation tool.
2. Evaluate changes implemented as part of the Study component of the PDSA to adjust the plan as needed and repeat the PDSA until it is a sustainable process.

Practice Attestation Anchor:
Demonstrate through attestation of use of a tool that provides cost and utilization data, such as Medicaid's Statewide Data Analytics Contractor (SDAC), Stratus, QRUR reports from Medicare, etc.

Practice Facilitator Attestation Methodology:
Attest if practice is learning to review and use a utilization aggregation tool. Document in monthly field notes.

**YEAR 2**

**BB2.Y2.1. Practice reviews CQM data to inform rapid cycle improvement processes.**

Action Items:
1. Continue Year 1 activities to sustain utilization data review.
2. Review your practice’s performance on CQMs and compare it to other SIM practices.

Practice Attestation Anchor:
Document the use CQM data in ongoing quality improvement efforts to improve care, such as through improvement team minutes.

Practice Facilitator Attestation Methodology:
Documentation in monthly PF and CHITA field notes. PF can attest if practice meets the milestone by specifically using CQM data in QI efforts.

**BB2.Y2.2. Practice develops processes for providing performance feedback to providers, including CQM, cost, and utilization data.**

Action Items:
1. Review reporting requirements for any health plan programs in which your practice participates.
2. Select which data (including CQM, cost and utilization data) will be used for performance feedback, and develop strategy for how this will be presented to providers.
3. Share QI data with all clinic staff via clinic-wide meetings or displays in a central area.

Practice Attestation Anchor:
Document CQM, cost, and utilization data being tracked and process for sharing with providers.
**Practice Facilitator Attestation Methodology:**
Attest if there is evidence that performance feedback is provided to providers.

**BB2.Y2.3. Practice conducts regular PDSA/QI activities on identified CQMs.**

**Action Items:**
1. Set a goal for how often you will complete PDSA cycles on CQMs; revisit this goal in QI team meetings at least annually.
2. After ensuring that your prior PDSA is complete and has become a sustainable process, return to action items in BB2.Y1.3 and select another CQM to focus on next.

**Practice Attestation Anchor:**
Document use of data for targeted CQMs as part of ongoing, regular QI activities through improvement team minutes.

**Practice Facilitator Attestation Methodology:**
Document in monthly PF and CHITA field notes. PF can attest if practice QI efforts specifically use CQM data.

**Building Block 3: Practice population is empaneled**

**Goal:** Practice has, and maintains, at least 75% of its patient population empanelment.

**Overview:**
Empanelment identifies the patients and population for whom the provider and/or care team is responsible and is the foundation for establishing continuity between patient and provider/care team. 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 when a provider leaves the practice. Empanelment improves patient and care team satisfaction, improves receipt of preventative services, as well reducing hospital admissions and ED visits. For community mental health centers integrating primary care, there may be separate panels for the primary care provider and the psychiatrist. For the purposes of SIM, the patient panel should be aligned with the primary care provider.

**CPC+ definition of “active patients”:** Active patients refers to patients who received primary care at your practice looking back over a given period. Your practice should define a look back period that is at least 18 months. The specific look back period will depend on your practice’s processes to track
patient encounters and your patient population. Typically, practices use a look-back period from 18 to 36 months.

**BB3.Y1.1. Practice has assessed patient panel and assigned PCPs/care teams to 75% of patient population.**

**Action Items:**
1. Review empanelment options with key clinicians and staff.
2. See Resource Hub for [empanelment resources](#). Determine empanelment methodology and workflow and document agreed upon procedures.
3. Implement chosen empanelment strategy, assigning all active patients to a provider panel.

**Practice Attestation Anchor:**
Attest that the practice has empaneled at least 75% of active patients to PCPs and/or care teams, and be prepared to present data supporting this.

**Practice Facilitator Attestation Methodology:**
Confirm the empanelment process used and attest if the practice has accomplished 75% empanelment.

**BB3.Y1.2. Practice reviews payer attribution lists monthly.**

**Action Items:**
1. Review payer(s) methodologies for distribution of attribution reports and their methodology for reconciling discrepancies.
2. Review attribution reports and lists of patients and compare against empanelment panels within one week of receipt.
3. Practice actively follows payer(s) methodologies within one month of receipt of attribution lists to reconcile any discrepancies.
4. Monitor concordance between internal empaneled patients and payer attribution reports.

**Practice Attestation Anchor:**
Attest that payer attribution lists are reviewed by someone at the practice or organization on a monthly basis.

**Practice Facilitator Attestation Methodology:**
P,F can attest if practice meets the milestone as described in the anchor statement.

**BB3.Y1.3. Practice designs and implements processes for validating PCP/care team assignment with patients.**

**Action Items:**
1. Confirm empanelment assignments with providers and patients.
2. Develop a plan for empanelment of new patients.
3. Monitor extent of empanelment through EHR or other reports to determine percentage of patients empaneled.

Practice Attestation Anchor:
Attest to having a process for assigning patients to primary care providers or care teams and validating those assignments on an ongoing basis.

Practice Facilitator Attestation Methodology:
Confirm practice has implemented a process of assigning patients to PCPs/care teams. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

YEAR 2

BB3.Y2.1. Practice maintains 75% empanelment of patients with provider/care teams.

Action Items:
1. Run reports regularly (i.e., quarterly) to determine empanelment status. Update empaneled patients as necessary to rebalance provider/care team panels and assign un-empaneled patients.

Practice Attestation Anchor:
Document process for regularly monitoring and adjusting empanelment and run report to demonstrate that 75% of active patients are empaneled.

Practice Facilitator Attestation Methodology:
Confirm empanelment process. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

BB3.Y2.2. Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage.

Action Items:
1. Review and adjust empanelment methodology based on practice needs and experience. Develop written policies documenting definitions and strategy.
2. 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.
3. Consider the following steps for calculating continuity:
   a. Numerator: Obtain the number of patients of Provider X that were seen by Provider X in the past month by reviewing the appointment schedule.
   b. Denominator: Obtain the total number of patients of Provider X that were seen over the past month.
   c. Divide the numerator by the denominator (and multiply by 100). This is the percentage of continuity for Provider X.
4. Repeat continuity tracking on a regular basis and review results with QI team.
5. Adjust scheduling, empanelment, patient communications, and workflows to improve continuity rates. A suggested target for continuity rates is 75%; however, some practices with additional challenges for meeting continuity rates (e.g. residency practice) may need to set a lower target.

6. Develop strategies and tools for informing patients and families about the importance of continuity of care (e.g. reminders to schedule next appointment with your doctor; protocols for scheduling appointments with the same provider over time; appointment reminders with provider names and pictures).

**Practice Attestation Anchor:**
Document policies for these aspects of empanelment (which ideally should be part of the process developed in year 1).

**Practice Facilitator Attestation Methodology:**
Confirms practice site has implemented policies to support empanelment. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**Building Block 4: Practice provides team-based care**

**Goal:** The care team uses shared operations, workflows, 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.

**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 and chronic care. Teamwork in the primary care practice has been shown to improve clinical quality, patient experience, 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. By working together in a team, physicians 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. As a result of teamwork, all members of the practice team are valued and feel engaged in 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 protocols and 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.
**YEAR 1**

**BB4.Y1.1. Practice uses established tool to assess baseline team relationships.**

**Action Items:**
1. Complete a practice assessment of the distribution of patient care tasks by role to measure how practice teams are functioning.

**Practice Attestation Anchor:**
Attest that team relationships were assessed and reviewed. Examples of relationship tools could include review of the Medical Home Practice Monitor and the Clinician and Staff Experience Survey, both collected as part of the SIM Assessments.

**Practice Facilitator Attestation Methodology:**
Confirm review with the practice or practice's quality improvement team of the results of the Medical Home Practice Monitor and the Clinician and Staff Experience Survey, plus any other similar tools the practice site may have used for this purpose.

**BB4.Y1.2. Practice has written job descriptions, including clear roles and responsibilities.**

**Action Items:**
1. Develop clear roles and responsibilities for each team member and put these in writing with a policy and procedure that outlines the process and decisions made.
2. Develop a plan for when staff turnover occurs to ensure tasks continue to done as planned.

**Practice Attestation Anchor:**
Produce written job descriptions for at least two roles in the practice (e.g., front desk, MA, RN, etc.) and attest that others are in place.

**Practice Facilitator Attestation Methodology:**
Confirm review of at least two job descriptions, with practice confirmation that others are in place.

**BB4.Y1.3. Practice identifies and implements a team-based care strategy (team huddle, collaborative care planning).**

**Action Items – Daily Team Huddles:**
1. Create a template agenda for daily huddles that includes the topics that will be discussed each day. Huddles may include time to:
   a. Prospectively plan for patients who can benefit from pre-visit activities (e.g., point of care tests, immunizations, paperwork) and extra time and assistance.
   b. Communicate and prepare for staff, provider, or equipment changes.
2. Adjust huddle timing, participants, and agenda as needed to best align the team at the start of a clinic session, build team culture, and improve communication for a more engaged workforce.
**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 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. Include a varied group of relevant team members such as providers, patients and families, nurses, medical assistants, care coordinators, behavioral health specialists, 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.

**Practice Attestation Anchor:**
Attest that at least one of the following team based care strategies are in routine use as outlined below:

- Team Huddle: occur at least once a week, involve more than one role on the team, and have some form of documentation (e.g., written scripts, standing agenda items for huddles, huddle checklists, EHR fields for virtual huddles, written procedures or instructions, etc.)
- Collaborative Care Planning: occur at least quarterly, include two or more team members (physician, BH provider, care manager, nursing, social worker, etc.) and have summary of the plan that includes patient goals within the patients' records.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of team-based care strategies. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB4.Y2.1. Practice reevaluates team relationship using tool from Year 1.**

**Action Items:**

1. Complete the practice assessment of the distribution of patient care tasks by role used in Year 1 to re-evaluate how practice teams are functioning.

**Practice Attestation Anchor:**
Repeat assessment and discussion of team relationships, as described for Year 1.

**Practice Facilitator Attestation Methodology:**
Confirm review with the practice or practice site’s quality improvement team of the results of the Medical Home Practice Monitor and Clinician and Staff Experience Survey, plus any other similar tools the practice may have used for this purpose, including comparing to baseline results.
BB4.Y2.2. Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure).

Standing orders are protocol-based workflows that care team members can follow based on 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.

Action Items:

1. Select which clinical quality measures (CQMs) will be targeted for standard protocols. Some standing orders relevant to SIM CQMs to consider include:
   a. Well-child and annual visits prompting developmental screening, substance abuse screening, fall risk assessment, and orders for age-appropriate cancer screening. Consider screening for maternal depression at postpartum visits or the 2 week newborn visit.
   b. Disease-based triggering of periodic services, such as A1C testing for patients with diabetes, and filling out a PHQ-9 for patients with depression.
   c. You may also want to consider standing orders for additional targets outside of the SIM CQMs such as appropriate immunization administration at well-child and annual visits; other recommended services for diabetes such as monofilament exams, eye referrals, and urine microalbumin; and symptoms triggering point of care testing for urinary tract infections, pregnancy, influenza, or and strep throat.

2. Develop a written protocol that explains qualifying patient conditions, recommended approach for management of the condition, 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 retrain and update providers and staff with the new information.

Practice Attestation Anchor:
Demonstrate protocols and workflows related to the three chosen quality measures.

Practice Facilitator Attestation Methodology:
Confirm practice implementation of protocols and workflows related to three chosen quality measures. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.
BB4.Y2.3. **Practice reviews roles/responsibilities for team-based care activities to ensure accountability for various tasks assigned.**

**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 leader(s) of each practice team.
   - b. Establish and provide organizational support for the teams, including protected time for teams to interact and plan their activities.
2. Distribute the workload throughout the team to make optimal use of each member’s training and skill set, having members work at the top of their license to the extent possible. Develop training for team members on new skills.
3. 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.

**Practice Attestation Anchor:**
Document roles and responsibilities for the various team-based activities.

**Practice Facilitator Attestation Methodology:**
Confirm implementation of screening. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**Building Block 5: Practice has built partnership with patients**

**Goal (adult):** Practice uses evidence-based, shared decision-making aids or self-management support tools for at least three preference-sensitive conditions including at least one behavioral health condition, and tracks use of tools. Practice establishes a Patient and Family Advisory Council (PFAC) to provide input, feedback on practice transformation activities and programs.

**Goal (pediatric):** Practice uses 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 establishes a PFAC to provide input and feedback on practice transformation activities and programs.

**Goal (combined):** 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.

**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 about health care. Shared Decision-Making (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 patient surveys, and by 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.

**YEAR 1**

**BB5.Y1.1. Practice evaluates patient population to identify one *preference-sensitive condition that is appropriate for decision aids or self-management support tools.*

*Preference-sensitive conditions are those which have treatment options that pose tradeoffs that the patient should consider with his/her physician when determining whether to proceed with treatment.*

**Action Items:**

1. Educate care team members on the concepts of self-management support and available tools.
2. Choose preference-sensitive conditions (three for adults including one behavioral health condition; one preference-sensitive condition in pediatrics) 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.

Practice Attestation Anchor:
Indicate the condition(s) chosen for this activity.

Practice Facilitator Attestation Methodology:
Confirm the practice has chosen three conditions and document this in field notes, along with any changes or additions through the initiative.

**BB5.Y1.2. Practice identifies and selects evidence-based decision aids or self-management support tools for identified conditions.**

**Action Items:**
1. 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. 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.

Practice Attestation Anchor:
Describe the selected decision aids or self-management tools.

Practice Facilitator Attestation Methodology:
Confirm practice implementation of decision aids or self-management tools. Attest if, in PF opinion, the practice has fully accomplished the milestone as described in the anchor statement.

**BB5.Y1.3. Practice has established a Patient and Family Advisory Council (PFAC) that meets at least quarterly.**

**Action Items:**
1. Identify one or two practice champions to co-facilitate the 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 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. A PFAC has been found to be one of the most effective ways to obtain patient and family feedback for a practice, and is recommended as the first choice for patient/family engagement in this milestone. If a PFAC is not felt to be feasible for the practice at this time, additional patient and family engagement strategies to consider include patient satisfactions surveys, adding a patient representative to the practice quality improvement team, or conducting patient focus groups to gather patient feedback.

Practice Attestation Anchor:
Provide minutes or other records of quarterly PFAC meetings and documentation of decisions made based on PFAC input.

Practice Facilitator Attestation Methodology:
Confirm practice implementation of PFAC meetings. Periodically review minutes or other records of PFAC meetings for discussion in quality improvement team meetings. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**YEAR 2**

**BB5.Y2.1. Practice identifies patients and families eligible for selected decision aids or self-management support tools.**

**Action Items:**
1. Establish a method for identifying the denominator of eligible patients to enable evaluation of the proportion of eligible patients that receive the aid or tool.
2. Determine how patients will be identified or flagged for the aid or tool at the point of care.

Practice Attestation Anchor:
Attest that process for targeting patients for decision aids or self-management support has been developed and implemented.

Practice Facilitator Attestation Methodology:
Confirm practice has identified patients eligible for selected decision aids or self-management support tools. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.
BB5.Y2.2. Practice implements decision aids or self-management support tools and establishes protocol and workflow for use.

**Action Items:**
1. Develop workflow for when and how decision aids or self-management support tools will be used, including which team member will review the aid or tool with the patient.
2. Train appropriate care team members and providers on when and how to use the tools.

**Practice Attestation Anchor:**
Attest that workflow for implementation of decision aids or self-management support tools has been developed and implemented, with documentation of use as in BB5.Y2.3.

**Practice Facilitator Attestation Methodology:**
Confirm practice development of workflow. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

BB5.Y2.3. Practice develops process for tracking and evaluating use of decision aids or self-management support tools.

**Action Items:**
1. 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.
2. Use patient input on the tools to make them optimally appropriate for your patient population.
3. Monitor patient satisfaction with self-management tools and adjust approaches to increase impact of these tools on patient outcomes.

**Practice Attestation Anchor:**
Describe processes for tracking the use and impact of shared decision making tools and provide data documenting their use.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of process. Attest if in PF opinion the practice site has fully accomplished the milestone as described in the anchor statement.

BB5.Y2.4. Practice uses PFAC to evaluate care experience.

**Action Items:**
1. Create a process for review of feedback from PFAC (such as through regularly scheduled QI team meetings) or other patient engagement strategy used. As noted in BB5.Y1.3., additional patient and family engagement strategies include patient satisfactions surveys, adding a patient representative to the practice quality improvement team, or conducting patient focus groups to gather patient feedback.
2. Share patient feedback with providers in the clinic through all-staff clinic meetings, practice email updates, or other means of communication that will be relayed to all staff.
3. 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).

**Practice Attestation Anchor:**
Document PFAC suggestions used to evaluate and improve patient experience of care through PFAC and or improvement team minutes.

**Practice Facilitator Attestation Methodology:**
Confirm review of PFAC minutes or other records of meetings and identify how practice is working on patient experience of care. Attest if, in PF opinion, the practice has fully accomplished the milestone as described in the anchor statement.

**Building Block 6: Practice risk stratifies and actively manages patient population using data.**

**Goal:** Practice uses population-level data to manage care gaps, develop care management care plans and implement those plans for high-risk patients/families.

**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 (generally 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.

The goal of this building block is to help practices successfully identify and develop care plans for patients with increased needs or at higher risk.

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, and 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: A risk score is calculated 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 common threshold categories include high cost utilization, such as patients with 4+ ER visits in a year or anyone with a 30 day readmission 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.

YEAR 1


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.
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.

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.

Practice Attestation Anchor:
Document a chosen risk stratification methodology that specifically fits the needs and resources of your practice. Note the potential alignment with activities described for BB10.

Practice Facilitator Attestation Methodology:
Confirm practice identification of a risk stratification methodology. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.
BB6.Y1.2. Practice identifies strategy to identify care gaps (e.g., patient registry, data aggregation tool) and prioritize high-risk patients/families.
Registries (or other means to identify care gaps/target populations) track 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. depression) or span a broader subpopulation of the clinic (e.g. wellness registry).

**Action Items:**
1. Engage the QI team to identify priority conditions to be tracked.
2. When making a new registry consider:
   a. The source of the data (e.g., EHR, claims, other population health registry).
   b. Patient diagnostic criteria (e.g., all depression or only depression on medications).
   c. The need for additional medication management and review (e.g., polypharmacy, frequent hospitalizations with changes to medications).
   d. 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.

**Practice Attestation Anchor:**
Attest to the development of a strategy and workflow for identification of care gaps for high risk patients and families, including use of a patient registry, data aggregation tool, or similar process.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of strategy and workflow. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.

**YEAR 2**

BB6.Y2.1(A). 75% of empaneled patients are risk-stratified. (adult only)

**Action Items:**
1. 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.

**Practice Attestation Anchor:**
Provide data indicating that this target has been met.

**Practice Facilitator Attestation Methodology:**
Review practice data and attest if target is met.
BB6.Y2.2. **75% of high-risk patients/families have a documented care plan.**

Individualized patient treatment plans, also known as “shared 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 members 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 (e.g., adults vs. children, patients seeing multiple specialists vs. healthy individuals). Include medication reconciliation in the creation and updating of care plans.
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. Develop a process to update the care plans regularly to keep all team members up to date.

**Practice Attestation Anchor:**
Provide data indicating the presence of the care plan developed in BB10.Y1.3 for 75% of high risk patients.

**Practice Facilitator Attestation Methodology:**
Review practice data and attest if target is met.

BB6.Y2.3. **Practice implements proactive care gap management and tracks outcomes.**

**Action Items:**
1. Based on previously selected strategy to identify care gaps (e.g., registry), contact patients who are not achieving pre-specified outcomes.
2. Engage care team members such as care managers, front desk staff, and others in patient follow-up as needed.
3. 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.
4. Once improvements are sustained, consider focusing on new outcomes and/or new registry populations.
**Practice Attestation Anchor:**
Attest to the implementation of a process for providing care management for high risk patients and the outcomes of the care management.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of an embedded care plan in EHR or another method for tracking the care plan. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB6.Y2.4. Practice embeds care plan template in EHR.**

**Action Items:**
1. Decide where in the EHR the individualized care plan will be documented.
2. Consider how individualized care plans could be shared, with proper permissions, across medical specialties within the medical neighborhood.

**Practice Attestation Anchor:**
Demonstrate that the care plan is embedded in the EHR, or show another method for tracking and sharing the care plan if that is not possible.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of an embedded care plan in EHR or another method for tracking the care plan. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**Building Block 7: Practice screens for behavioral health and substance use disorders and links primary care to behavioral health and social services.**

**Goal:** 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.

**Overview:**
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 clinics 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.

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.

**YEAR 1**

**BB7.Y1.1. Practice identifies behavioral health resources for patients/families, including support from SIM participating health plans and Regional Health Connectors (RHCs).**

**Action Items:**
1. Contact SIM participating plans and identify what behavioral health resources are available through the plan.
2. Contact Regional Health Connector to assist in identifying community resources and priorities.
3. Create repository of available behavioral health resources, including local public health agencies.

**Practice Attestation Anchor:**
Attest to having assessed and identified local behavioral health resources appropriate for the practice's patient population.

**Practice Facilitator Attestation Methodology:**
Confirm practice effort to identify appropriate local behavioral health resources. Attest if in PF opinion the practice has fully accomplished the milestone.

**BB7.Y1.2. 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.**

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 allows 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. Work with the care team and QI team to choose at least two age- and developmentally-appropriate screening tools for behavioral health conditions measured by the SIM CQMs (depression, maternal depression, developmental disorders, unhealthy alcohol use, and tobacco use).
2. Regularly monitor the use of the tools to track the reach of your screening - the number of patients being screened over the total targeted number of patients. Explore if your EHR is also capable of tracking appropriate follow-up of positive screening tests and patient outcomes over time.
3. If <25% of patients receive a behavioral health screening test, consider adjusting current workflows or implementing additional screening tools.

**Practice Attestation Anchor:**
Show the tool(s) used to screen for depression, maternal depression, developmental disorders, tobacco use, unhealthy alcohol use, and/or other substance use disorder. Produce a measure showing that at least 25% of targeted patients were screened with the tool.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of a screening tool. Attest if in PF opinion the practice site has fully accomplished the milestone as described in the anchor statement.

**BB7.Y1.3. Practice has documented process for connecting patients/families with behavioral health resources (from screening), including standing orders and/or protocols and follow-up.**

**Action Items.**

1. Start by listing the discrete behavioral health screenings (see BB7.Y1.2.), treatments provided in the practice, and behavioral health resources available to patients (see BB7.Y1.1., BB7.Y2.3., BB8.Y1.2.), along with the descriptions of patients who qualify for the interventions.
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. Identify how the results will be communicated to the providers and care team.
   a. Consider which screening protocols 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. Design alerts and workflow notifications, as able, 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. Identify/designate the appropriate staff to respond and initiate protocols related to different types of screening outcomes.

Practice Attestation Anchor:
Produce documentation of the standing orders or protocols.

Practice Facilitator Attestation Methodology:
Confirm practice site implementation of standing orders or protocols. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.

YEAR 2

BB7.Y2.1. 50% of patients are screened for behavioral health conditions.

Action Items:
1. Expand on the use of tools to screen for behavioral health conditions as selected in BB7.Y1.2. If <50% of patients are receiving a behavioral health screening test, consider adjusting current workflows or implementing additional screening tools. As noted in BB7.Y1.2, behavioral health screening measures included in the SIM CQMs are depression, maternal depression, developmental disorders, unhealthy alcohol use, and tobacco use.
2. Continue to regularly monitor the use of these tools to track the number of patients being screened. If not already done, explore if your EHR is also capable of tracking appropriate follow up of positive screening tests and patient outcomes over time.

Practice Attestation Anchor:
Demonstrate that at least 50% of patients are screened for key behavioral health conditions, chosen as appropriate for the patient population.

Practice Facilitator Attestation Methodology:
Confirm review of practice data to assure that at least 50% of patients are screened for key behavioral conditions.

BB7.Y2.2. Practice performs an assessment of community resources, with Regional Health Connector support when possible, to assist patients with social needs (such as food, housing, transportation).

Action Items:
1. Determine screening questions that you will use to identify specific social needs in your patients.
2. Work with your Regional Health Connector (RHC) to develop a repository of community resources available to patients with social needs.
3. Determine who in the practice will be responsible for maintaining a list of community resources that relate to the patient population served.
4. Create protocol to define how to access community supports.

Practice Attestation Anchor:
Provide documentation of the assessment of community resources to assist patients with social needs. This can include the use of formal external assessments of such resources.

Practice Facilitator Attestation Methodology:
Confirm practice assessment of community resources. RHC may be able to assist. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.

BB7.Y2.3. 50% of patients identified with behavioral health need are connected to resources.

Action Items:
1. Set as your denominator for this measure the patients that screened positive for targeted behavioral health conditions using the tools in BB7.Y1.2./BB7.Y2.1.
2. If your practice provides integrated BH interventions, develop a process for measuring how many qualifying patients are seen in a month and how many receive the intervention(s).
   a. 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.
   b. Consider alternatives to traditional office visits to provide interventions through other points of access, such as management via home visits, group visits, phone, email, or patient portal.
3. If your practice refers patients who screen positive to outside BH resources, create a written protocol to track referrals and referral uptake/completion for offsite BH services. Offsite BH resources may include psychology, psychiatry, early intervention programs, and local community health programs.
   a. See BB8.Y1.2. for additional action items on assessment of referral pathways to offsite BH resources and BB7.Y1.1. for other identification of resources.
   b. 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 bi-directional 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.
c. Include a definition of a “reasonable time” that makes sense for the practice and patients.
d. Delineate a care team member to be responsible for tracking this process.
e. 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.

Practice Attestation Anchor:
Provide data indicating that 50% of patients identified with behavioral health needs are connected to resources; can include resources within or outside the practice.

Practice Facilitator Attestation Methodology:
Review practice site's data to assure that at least 50% of patients with behavioral health needs are connected to resources. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.

Building Block 8: Practice provides prompt access to care, including behavioral health care.

Goal: 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.

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 manner, leading to increased expenses and poorer health. Access is important day or night, as is provider access to patient information. This level of access promotes continuity of care by enhancing communication and promoting integration between services. Many strategies such as 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 a 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 and 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.

Care compacts are collaborative agreements that facilitate coordination 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 and vice versa, or an agreement of who is managing the ongoing care of the patient. Beyond specialty medical and behavioral health providers, care compacts are also 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.

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.

**BB8.Y1.1. Practice representative has EHR access available 24 hours, 7 days per week.**

**Action Items:**

1. Develop a written protocol for providers to have access to patient 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 (e.g., a nurse triage line, an on-call provider who is not part of the practice, or the patient’s primary care provider). 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.

**Practice Attestation Anchor:**

Attest or provide documentation that after hours call providers have access to the practice’s own EHR and patient records.
Practice Facilitator Attestation Methodology:
Confirm that this milestone has been met. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

BB8.Y1.2. Practice performs assessment of referral pathways and available after-hours support for behavioral health, working with RHCs when possible.

Action Items:
1. Identify policies and procedures on how crisis intervention, urgent care, 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.
2. Determine how referrals are made and which patients are referred.
3. 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) and denote specializations in the resource lists. 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. 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. Regional Health Connectors can assist practices with this information gathering and relationship building.
3. Review and update this list regularly to ensure accuracy. Assign someone in the practice to keep this resource up to date.
4. 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 or Regional Accountable Entity.

Practice Attestation Anchor:
Attest to development of a pathway for at least one type of referral to behavioral health (preferably one that fits with the reported CQMs and other practice QI efforts), including mechanism for after-hours support.
Practice Facilitator Attestation Methodology:
Confirm practice development of a pathway for at least one type of referral to behavioral health. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB8.Y1.3. Practice identifies data sources and technology needed for bi-directional data sharing.**

**Action Items:**
1. Determine what confidentiality agreements/releases of information will be required for bi-directional data sharing with the behavioral health providers in your referral pathways.
2. Identify what EHR capabilities are available to send and receive patient data to clinicians outside of the medical home, including how and where outside records can be stored and accessed.

Practice Attestation Anchor:
Describe what is needed to accomplish bi-directional data sharing with behavioral health partners, whether integrated or separate from the practice.

**Practice Facilitator Attestation Methodology:**
Confirm that the practice has explored data sources and technology for bi-directional data sharing with behavioral health partners.

**YEAR 2**

**BB8.Y2.1. Practice establishes a collaborative agreement with at least one behavioral health provider.**

**Action Items:**
1. Review templates for creating a care compact.
2. Determine a beneficial BH practice with whom to develop a care compact based on the needs of your practice and patient panel. For many practices, including those with an integrated behavioral provider, this could include a Community Mental Health Center, a psychiatry practice, or another provider of specialty behavioral health care.
3. Have a medical director or other clinic leader reach out to these BH providers to gauge interest in care compact agreements.
4. Work collaboratively with partners to create mutually beneficial care compact.
5. Ensure care team can articulate how to use agreements.

Practice Attestation Anchor:
Document the collaborative agreement.
**Practice Facilitator Attestation Methodology:**
Confirm the development of at least one collaborative agreement. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB8.Y2.2. Practice develops plan for bi-directional data sharing with behavioral health provider.**

**Action Items:**
1. Develop a process for data sharing for patients known to be under the care of outside behavioral health providers, such as through the use of EHR template letters containing clinic notes that can be automatically faxed or mailed to the behavioral health provider (or primary care provider in the case of CHMCs) after completion of the note.
2. Plan protocols for how received records will be delivered, to whom they will be delivered, and how they will be reviewed (i.e., expectation of timeliness, if/where outside records can be scanned into the EHR, if it is appropriate to make other documentation or summarize outside information elsewhere in the patient’s chart).

**Practice Attestation Anchor:**
Attest to having a plan for bi-directional data sharing. Explain barriers if unable to implement plan at this time.

**Practice Facilitator Attestation Methodology:**
Attest if a plan for bi-directional data sharing has been developed.

**Building Block 9: Practice provides comprehensive care coordination for primary/behavioral healthcare**

**Goal:** Practice has reduced total cost of care while maintaining or improving quality of care for patients, including those with depression and substance abuse disorders, compared with non-SIM practices.

**Overview:**
The milestone activities in this building block focus on strengthening care coordination at times of care transitions from the hospital or ED to the medical home and monitoring the total cost of care for patients to help determine cost drivers.

**BB9.Y1.1. Practice can identify total cost of care for patient panel, and subset of patients with behavioral health conditions.**

**Action Items:**
1. Using data aggregation tool, identify the total cost of care for your entire patient population.
2. Identify the total cost of care specific to the subset of patients that have behavioral health conditions.
**Practice Attestation Anchor:**
Attest to use of cost and utilization tool to identify the cost of care for all patients and for those with at least one specific behavioral health condition. Document use of this data in improvement team minutes.

**Practice Facilitator Attestation Methodology:**
Confirm practice use of cost and utilization tools. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB9.Y1.2. Practice identifies and implements policy and procedures that include timely follow-up for emergency department (ED) and hospital admissions.**

**Action Items:**
1. Determine if and how the practice is receiving hospital admission and discharge notification where patients are accessing care.
2. Determine who will be responsible for contacting patients after hospitalization or ED visit, such as a care manager, clinic nurse, or patient navigator.
3. Develop a written policy that describes practice plan for following up with patients post-discharge from the hospital or ED.
4. Create flexibility in provider schedules to allow for ease of scheduling follow up appointments within 72 hours or one week (as appropriate) after ED visit or hospitalization. This may include blocking a specific number of appointments for this explicit purpose or blocking appointments for urgent needs that can only be scheduled within the preceding 72 hours.

**Practice Attestation Anchor:**
Attest to implementation of policies and procedures for transitions of care for hospitalizations and ED visits.

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of policies and procedures for transitions of care for hospitalization and ED visits. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**YEAR 2**

**BB9.Y2.1. Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation.**

**Action Items:**
1. Implement policy from BB9.Y1.2. that describes practice plan for following up with patients post-discharge from hospital or ED. Follow-up could include phone call, office visit or other encounter as appropriate.
2. Track the numerator and denominator of patients hospitalized and seen in the ED to ensure at least 50% of patients are contacted.
3. Prioritize contacting patients for medication reconciliation and determination of follow up needs for those with chronic conditions or frequent hospital/ED utilization.
4. Include in the medication reconciliation process ascertainment of patient self-reports of medication adherence, including issues of side effects, forgotten doses, and financial costs. For patients with low adherence, pill counts can be selectively used for critical meds. If appropriate and with patient consent, engage family members and caregivers in medication adherence discussions.

**Practice Attestation Anchor:**
Provide data demonstrating that at least 50% of patients are contacted within 7 days of hospitalization or ED visit.

**Practice Facilitator Attestation Methodology:**
Review practice data regarding contact of patients after hospitalization or ED visit. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB9.Y2.2. Practice identifies cost drivers for patients with behavioral health condition(s) and incorporates in QI processes.**

**Action Items:**
1. Examine the cost data from BB9.Y1.1. and evaluate what behavioral health conditions, co-morbidities, medications, demographics, and other patient characteristics are associated with higher costs.
2. Review this data in QI meetings and use to help guide priority areas to address for patients with behavioral health conditions.

**Practice Attestation Anchor:**
Document QI process for improving cost of care for at least one behavioral health condition through improvement team minutes.

**Practice Facilitator Attestation Methodology:**
Assist practice in QI process to improve cost of care for at least one behavioral health condition. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB9.Y2.3. Practice creates and reports a measurement to assess impact and guide improvement on at least one of the following:**
   a. Notification of ED visit in a timely fashion
   b. Medication reconciliation process completed within 72 hours
   c. Notification of admission and clinical information exchange at the time of admission
   d. Information exchange between primary care and specialty care related to referrals
Action Items:

1. Select an area of focus based on patient population needs and identify a point person to review this data in QI meetings.

2. Develop a process for assessing the targeted measure and determining improvement.
   b. For medication reconciliation process completed within 72 hours of discharge from hospital or ER, you will need to determine how you will measure a denominator and numerator. There may be EHR functionalities that can be implemented for tracking.
   c. For information exchange between primary care and specialty care related to referrals, you may want to consider developing a specialty care compact with the specialists patients are most commonly referred to. Contact your local HIE who may have information on tools to make this easier. Your CHITA or PF can help connect you to the HIE.

Practice Attestation Anchor:
Document the measure and the results of the improvement process through improvement team minutes.

Practice Facilitator Attestation Methodology:
Confirm practice work to measure improvement process. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

Building Block 10: Practice has fully integrated behavioral health care to provide whole-person care

Goal: 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.

Overview:
This building block advances the skills developed in other building blocks to further grow the practice’s ability to meet the behavioral health needs of their patient population. Tracking and adjusting protocols based on outcomes, in addition to process measures, helps ensure that the care patients are receiving is achieving the goals of the practice. Fully integrating behavioral health allows more patients to have most of their physical and behavioral needs met in their medical home.
YEAR I

BB10.Y1.1. 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).

Action Items:
1. For assessment of referral pathways and available after hours support for behavioral health, see BB8.Y1.1 and BB8.Y1.2.
2. Work with RHCs when possible to access referral sources identified and other community resources.

Practice Attestation Anchor:
Attest to development and implementation of referral pathway.

Practice Facilitator Attestation Methodology:
Confirm practice implementation of a referral pathway for behavioral health needs. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

BB10.Y1.2. Practice develops a plan to systematically measure and track patient behavioral health outcomes.

Action Items:
1. Select behavioral health outcomes most relevant to your practice population. These may be in addition to the CQMs (for example, rates of smoking cessation), or you may use a CQM that is an outcome rather than process measure:
   a. Depression remission at 12 months (CPC+ CQM which counts for SIM)
   b. Hemoglobin A1c poor control (if targeting an appropriate population with behavioral health conditions, e.g., patients with comorbid depression and diabetes, or patients on antipsychotics)
   c. Controlling high blood pressure (as above, if targeting an appropriate population with behavioral health conditions).
2. Work with your CHITA to determine how data will be retrieved and accessed through your EHR.
3. Identify a practice champion to take the lead and be responsible for reviewing the data with your QI team, and plan how often this will occur.

Practice Attestation Anchor:
Attest to development of plan to systematically measure and track patient behavioral health outcomes for key conditions targeted by the practice.
**Practice Facilitator Attestation Methodology:**
Confirm practice reporting of chosen measures and outcomes and plan for extracting and tracking data. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB10.Y1.3. Practice develops care plans that include patient actions to manage behavioral health conditions.**

**Action Items:**
1. Select what population you will target for incorporating patient actions to manage behavioral health conditions into care plans. If you are concurrently working on BB6, this may be your high-risk population based on your risk stratification methodology including behavioral health conditions. Otherwise, you may choose to develop care plans for patients that screen positive for behavioral health conditions (BB7).
2. Educate providers on motivational interviewing and the use of self-management tools (if not already done through BB5).
3. Develop a protocol and/or a standardized form for care plans that includes either patient goal setting with action steps or identified self-management tools.

**Practice Attestation Anchor:**
Provide examples and evidence of ongoing use of the care plans.

**Practice Facilitator Attestation Methodology:**
Confirm practice use of care plans. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**YEAR 2**

**BB10.Y2.1. Practice systematically measures and tracks patient behavioral health outcomes.**

**Action Items:**
1. Implement the plan designed in year 1 (BB10.Y1.2.) by having your designated practice champion pull the appropriate reports at predetermined intervals on your behavioral health outcomes of interest.
2. Incorporate evaluation of these data into your QI team meetings.
3. Provide data feedback on these outcomes to providers along with the CQM, cost and utilization data specified in BB2.

**Practice Attestation Anchor:**
Provide data demonstrating systematic tracking of patient behavioral health outcomes for key condition(s) targeted by the practice.
**Practice Facilitator Attestation Methodology:**
Confirm presence of tracking data. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB10.Y2.2. Practice documents and implements protocols to identify and manage care for high-risk behavioral health populations.**

**Action Items:**
1. If not already done in BB6, develop a risk-stratification methodology that incorporates priority behavioral health condition(s). Refer to BB6.Y1.1(A).
2. Create a registry or develop an alternative strategy for identifying care gaps. Refer to BB6.Y1.2.
3. Target patients with identified care gaps with proactive management and outreach. See BB6.Y2.3.

**Practice Attestation Anchor:**

**Practice Facilitator Attestation Methodology:**
Confirm practice implementation of care management for chosen conditions. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.

**BB10.Y2.3. Practice identifies and implements at least two opportunities to adjust its protocols to improve behavioral health status of patients.**

**Action Items:**
1. Based on review of CQM, cost, utilization, patient experience, and other behavioral health outcome data in QI meetings, identify two clinic protocols or care processes with room for improvement to better meet goals for your patients with behavioral health needs.
2. Develop or adjust PDSA cycles (or other QI methodologies used) as necessary to improve these clinic protocols or care processes, including determining at what time interval you will review data to evaluate effectiveness of the change.

**Practice Attestation Anchor:**
Document how protocols have been adjusted to improve behavioral health status through improvement team minutes.

**Practice Facilitator Attestation Methodology:**
Confirm practice effort to improve protocols. Attest if in PF opinion the practice has accomplished the milestone in the anchor statement.
BB10.Y2.4. Practice demonstrates advanced access to behavioral health services including:

1. Real time and pre-planned direct patient interactions for mental health, substance abuse, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.
2. Pre-planned co-consultation with behavioral health provider, primary care provider, and patients/families.
3. Real time and asynchronous consultation with primary care team members.

Action Items:

1. Hire a behavioral health clinician, if not already done, to provide behavioral health services integrated into the practice. If available, consider hiring a behavioral health clinician with experience in integrated settings (in CMHCs, hire a primary care clinician if not already done to provide physical health service integrated into the practice).
2. Develop on-boarding training for the behavioral health clinician as well as training for the primary care clinician to learn how to best work together.
3. Create standard processes and workflows for how primary care and behavioral health clinicians will interact (e.g., via warm hand-off, co-consultation) and how they will document in the EHR. See BB4.Y1.3. and BB4.Y2.2. for related team-based care strategies.
4. Implement strategies to promote advanced access to integrated behavioral health services in the practice including:
   - Shared workspace of behavioral health and primary care providers
   - Short behavioral health provider appointment times
   - Blocks of unscheduled time for behavioral health providers to be available for co-consultation and warm hand-offs

Practice Attestation Anchor:
Attest to and be prepared to demonstrate full implementation (as described in the SIM Implementation Guide) of either: 1) one or more integrated behavioral clinicians; or 2) another fully developed model for identifying, treating, and monitoring patient behavioral issues that includes a closely coordinated relationship with external behavioral health resources.

Practice Facilitator Attestation Methodology:
Confirm practice implementation of advanced access to behavioral health services. Attest if, in PF opinion, the practice has fully accomplished the milestone as described in the anchor statement and the Implementation Guide.
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.

<table>
<thead>
<tr>
<th>BUILDING BLOCK</th>
<th>YEAR-1 MILESTONES</th>
<th>YEAR-2 MILESTONES</th>
<th>GOAL</th>
</tr>
</thead>
</table>
| 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 that includes SIM revenue and planned expenses.  
• 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 monthly.  
• 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. |
<table>
<thead>
<tr>
<th>BUILDING BLOCK</th>
<th>YEAR-1 MILESTONES</th>
<th>YEAR-2 MILESTONES</th>
<th>GOAL</th>
</tr>
</thead>
</table>
| 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. |
<table>
<thead>
<tr>
<th>BUILDING BLOCK</th>
<th>YEAR-1 MILESTONES</th>
<th>YEAR-2 MILESTONES</th>
<th>GOAL</th>
</tr>
</thead>
</table>
| **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. |
<table>
<thead>
<tr>
<th>Assessment Name/Tool</th>
<th>Assessment Purpose</th>
<th>Responsible for Filling Out</th>
<th>Responsible for Submitting</th>
<th>Frequency of Reporting</th>
<th>Expected Time to Complete (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Field Note</strong> (includes free text and check box fields)</td>
<td>Documentation of number of meetings/contacts and specific areas of focus as aligned with SIM Framework &amp; Milestones <em>aka Practice Transformation Building Blocks)</em></td>
<td>Practice Facilitator &amp; CHITA</td>
<td>Practice Facilitator &amp; CHITA</td>
<td>Monthly</td>
<td>10</td>
</tr>
<tr>
<td><strong>Medical Home Practice Monitor</strong></td>
<td>Practice self-assessment of level of implementation of core aspects of advanced primary care</td>
<td>Practice Team (led by Practice Facilitator)</td>
<td>Practice Champion</td>
<td>Baseline &amp; Annually</td>
<td>60</td>
</tr>
<tr>
<td><strong>Integrated Practice Assessment Tool (IPAT)</strong></td>
<td>Assesses current methods BHI along levels of coordination, co-location and integration</td>
<td>Practice Team (led by Practice Facilitator)</td>
<td>Practice Champion</td>
<td>Baseline &amp; Annually</td>
<td>10</td>
</tr>
<tr>
<td><strong>Clinician and Staff Experience Survey</strong></td>
<td>Individual provider and staff survey that assesses: 1) Clinician and Staff Experience and 2) Burnout</td>
<td>All Members of Practice</td>
<td>Each Practice Member</td>
<td>Baseline &amp; Annually</td>
<td>15</td>
</tr>
<tr>
<td><strong>SIM Milestone Attestation Checklist</strong> <em>(previously referred to as Milestone Activity Inventory)</em></td>
<td>Assesses practice's current implementation of SIM milestone activities and progress. Additionally, will provide mechanism for Practice Facilitator attestation.</td>
<td>Practice Team (led by Practice Facilitator)</td>
<td>Practice Team submits Draft Practice Facilitator submits Final</td>
<td>Baseline &amp; Every 6 Months <em>(updateable anytime)</em></td>
<td>60</td>
</tr>
<tr>
<td><strong>HIT Assessment</strong></td>
<td>Assesses practice's current state of data quality, validity of CQM reports and implementation of SIM’s other HIT priorities.</td>
<td>Practice Team (led by CHITA)</td>
<td>CHITA</td>
<td>Baseline &amp; Annually</td>
<td>60</td>
</tr>
<tr>
<td><strong>Clinical Quality Measures (CQMs)</strong></td>
<td>Track patient and process outcomes achieved by practices</td>
<td>Practice Champion (led by CHITA)</td>
<td>Practice Champion</td>
<td>Every Calendar Quarter</td>
<td>Variable</td>
</tr>
</tbody>
</table>
Colorado State Innovation Model (SIM) Clinical Quality Measures (CQMs) Reporting Summary
SIM Clinical Quality Measure (CQM) Reporting Schedules: Cohort 2

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# Cohort 2 CQM Reporting Schedules

**SIM Cohort 2 Practice Sites Participating in SIM Only**

## Adult Practice Sites

<table>
<thead>
<tr>
<th>Test period, practice sites report whatever they can</th>
<th>Choose 3 primary CQMs:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Depression Screening</td>
</tr>
<tr>
<td></td>
<td>• Diabetes: Hemoglobin A1c</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• Obesity: Adult</td>
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<tr>
<td></td>
<td>• SUD: Alcohol &amp; Other Drug Dependence</td>
</tr>
<tr>
<td></td>
<td>• SUD: Tobacco</td>
</tr>
<tr>
<td>Secondary CQMs (if needed):</td>
<td>Choose 4 primary CQMs:</td>
</tr>
<tr>
<td></td>
<td>• Depression Screening</td>
</tr>
<tr>
<td></td>
<td>• Diabetes: Hemoglobin A1c</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• Obesity: Adult</td>
</tr>
<tr>
<td></td>
<td>• SUD: Alcohol &amp; Other Drug Dependence</td>
</tr>
<tr>
<td></td>
<td>• SUD: Tobacco</td>
</tr>
<tr>
<td>Secondary CQMs (if needed):</td>
<td>Choose 5 primary CQMs:</td>
</tr>
<tr>
<td></td>
<td>• Depression Screening</td>
</tr>
<tr>
<td></td>
<td>• Diabetes: Hemoglobin A1c</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• Obesity: Adult</td>
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<tr>
<td></td>
<td>• SUD: Alcohol &amp; Other Drug Dependence</td>
</tr>
<tr>
<td></td>
<td>• SUD: Tobacco</td>
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<tr>
<td>Secondary CQMs (if needed):</td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2017 Q3 (Jul-Sep 17)</th>
<th>2017 Q4 (Oct-Dec 17)</th>
<th>2018 Q1 (Jan-Mar 18)</th>
<th>2018 Q2 (Apr-Jun 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report all 6 primary CQMs:</td>
<td>Same as Y2Q3</td>
<td>Same as Y2Q3</td>
<td>Same as Y2Q3</td>
</tr>
<tr>
<td>• Depression Screening</td>
<td>• Phase in additional secondary CQMs as appropriate</td>
<td>• Phase in additional secondary CQMs as appropriate</td>
<td>• Phase in additional secondary CQMs as appropriate</td>
</tr>
<tr>
<td>• Diabetes: Hemoglobin A1c</td>
<td>= 6 total CQMs required</td>
<td>= 6 total CQMs required</td>
<td>= 6 total CQMs required</td>
</tr>
<tr>
<td>• Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obesity: Adult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SUD: Alcohol &amp; Other Drug Dependence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SUD: Tobacco</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Secondary CQMs (if needed):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Asthma (new)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fall Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maternal Depression Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• SUD: Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>= 6 total CQMs required</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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2018 Q3 (Jul-Sep 18) | 2018 Q4 (Oct-Dec 18) | 2019 Q1 (Jan-Mar 19) | 2019 Q2 (Apr-Jun 19) |
<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
</table>
| 2017 Q3 (Jul-Sep 17) | Test period, practice sites report whatever they can | Choose 2 primary CQMs:  
  - Depression Screening  
  - Developmental Screening  
  - Maternal Depression Screening  
  - Obesity: Adolescent  
  Secondary CQMs (if needed):  
  - Asthma (new)  
  = 2 total CQMs required | Choose 3 primary CQMs:  
  - Depression Screening  
  - Developmental Screening  
  - Maternal Depression Screening  
  - Obesity: Adolescent  
  Secondary CQMs (if needed):  
  - Asthma (new)  
  = 3 total CQMs required | Report all 4 primary CQMs:  
  - Depression Screening  
  - Developmental Screening  
  - Maternal Depression Screening  
  - Obesity: Adolescent  
  Secondary CQMs (if needed):  
  - Asthma (new)  
  = 4 total CQMs required |
| 2018 Q3 (Jul-Sep 18) | Same as Y1Q2  
  - Phase in additional secondary CQMs as appropriate  
  = 4 total CQMs required | Same as Y1Q2  
  - Phase in additional secondary CQMs as appropriate  
  = 4 total CQMs required | Same as Y1Q2  
  - Phase in additional secondary CQMs as appropriate  
  = 4 total CQMs required | Same as Y1Q2  
  - Phase in additional secondary CQMs as appropriate  
  = 4 total CQMs required |
**SIM Cohort 2 Practice Sites Participating in CPC+** (see Appendix A for full list of CPC+ CQM reporting requirements)

### Adult Practices Sites

<table>
<thead>
<tr>
<th>2017 Q3 (Jul-Sep 17)</th>
<th>2017 Q4 (Oct-Dec 17)</th>
<th>2018 Q1 (Jan-Mar 18)</th>
<th>2018 Q2 (Apr-Jun 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test period, practice sites report whatever they can</strong></td>
<td><strong>Choose 3 primary CQMs:</strong></td>
<td><strong>Choose 4 primary CQMs:</strong></td>
<td><strong>Report all 5 primary CQMs:</strong></td>
</tr>
<tr>
<td></td>
<td>• Depression:</td>
<td>• Depression:</td>
<td>• Depression:</td>
</tr>
<tr>
<td></td>
<td>a) Depression Screening (SIM/QPP) <strong>OR</strong></td>
<td>a) Depression Screening <strong>OR</strong></td>
<td>a) Depression Screening <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>b) Depression Remission at 12 months (CPC+ group 1)</td>
<td>b) Depression Remission at 12 months</td>
<td>b) Depression Remission at 12 months</td>
</tr>
<tr>
<td></td>
<td>• Diabetes: Hemoglobin A1c (CPC+ group 1 &amp; SIM/QPP)</td>
<td>• Diabetes: Hemoglobin A1c</td>
<td>• Diabetes: Hemoglobin A1c</td>
</tr>
<tr>
<td></td>
<td>• Hypertension (CPC+ group 1 &amp; SIM/QPP)</td>
<td>• Hypertension</td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• SUD: Alcohol &amp; Other Drug Dependence (CPC+ group 2 &amp; SIM/QPP)</td>
<td>• SUD: Alcohol &amp; Other Drug Dependence</td>
<td>• SUD: Alcohol &amp; Other Drug Dependence</td>
</tr>
<tr>
<td></td>
<td>• SUD: Tobacco (CPC+ group 3 &amp; SIM/QPP)</td>
<td>• SUD: Tobacco</td>
<td>• SUD: Tobacco</td>
</tr>
<tr>
<td></td>
<td>** Secondary CQMs (if needed):**</td>
<td>** Secondary CQMs (if needed):**</td>
<td>** Secondary CQMs (if needed):**</td>
</tr>
<tr>
<td></td>
<td>• Asthma (SIM/QPP)</td>
<td>• Asthma</td>
<td>• Asthma</td>
</tr>
<tr>
<td></td>
<td>• Fall Safety (CPC+ group 2 &amp; SIM/QPP)</td>
<td>• Fall Safety</td>
<td>• Fall Safety</td>
</tr>
<tr>
<td></td>
<td>• Maternal Depression Screening (SIM/QPP)</td>
<td>• Maternal Depression Screening</td>
<td>• Maternal Depression Screening</td>
</tr>
<tr>
<td></td>
<td>• SUD: Alcohol (SIM/QPP)</td>
<td>• SUD: Alcohol</td>
<td>• SUD: Alcohol</td>
</tr>
<tr>
<td></td>
<td><strong>= 3 total CQMs required</strong></td>
<td><strong>= 4 total CQMs required</strong></td>
<td><strong>= 5 total CQMs required</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2018 Q3 (Jul-Sep 18)</th>
<th>2018 Q4 (Oct-Dec 18)</th>
<th>2019 Q1 (Jan-Mar 19)</th>
<th>2019 Q2 (Apr-Jun 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Same as Y1Q2</strong></td>
<td><strong>Same as Y1Q2</strong></td>
<td><strong>Same as Y1Q2</strong></td>
<td><strong>Same as Y1Q2</strong></td>
</tr>
<tr>
<td>• Phase in additional secondary CQMs as appropriate</td>
<td>• Phase in additional secondary CQMs as appropriate</td>
<td>• Phase in additional secondary CQMs as appropriate</td>
<td>• Phase in additional secondary CQMs as appropriate</td>
</tr>
<tr>
<td>= 5 total CQMs required</td>
<td>= 5 total CQMs required</td>
<td>= 5 total CQMs required</td>
<td>= 5 total CQMs required</td>
</tr>
</tbody>
</table>
# SIM Clinical Quality Measure Set

**Specifications and guidance found in SIM CQM Guidebook**

## Adult Measure Set

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>SIM Metric Title</th>
<th>Citation</th>
<th>CPC+</th>
<th>QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418</td>
<td>Depression Remission at 12 Months</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 2v6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>NQF 0059</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 122v5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 165v5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity: Adult</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan</td>
<td>NQF 0421</td>
<td>No obesity measure (not required for SIM if in CPC+)</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 69v5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol</td>
<td>Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment</td>
<td>NQF 0004</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>and Other Drug Dependence</td>
<td></td>
<td>CMS 137v5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder: Tobacco</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>NQF 0028</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 138v5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma</td>
<td>NQF 1799</td>
<td>No asthma measure</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Safety</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>NQF 0101</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 139v5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401</td>
<td>No maternal depression measure</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 82v4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>NQF 2152</td>
<td>Alcohol &amp; Other Drug Dependence measure (above)</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS n/a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Measures reported via APCD claims data automatically**

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>SIM Metric Title</th>
<th>Citation</th>
<th>CPC+ (clinical)</th>
<th>QPP (clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>Breast Cancer Screening</td>
<td>NQF 2372</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 125v5</td>
<td>(clinical)</td>
<td>(clinical)</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Colorectal Cancer Screening</td>
<td>NQF 0034</td>
<td>✓ (clinical)</td>
<td>✓ (clinical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 130v5</td>
<td>(clinical)</td>
<td>(clinical)</td>
</tr>
</tbody>
</table>
### Pediatric Measure Set

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>Metric Title</th>
<th>Citation</th>
<th>QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>✓</td>
</tr>
<tr>
<td>Development Screening</td>
<td>Developmental Screening in the First Three Years of Life (developed by Mathematica)</td>
<td>NQF 1448 CMS 664</td>
<td></td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>✓</td>
</tr>
<tr>
<td>Obesity: Adolescent</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NQF 0024 CMS 155v5</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma</td>
<td>NQF 1799 CMS n/a</td>
<td>✓</td>
</tr>
</tbody>
</table>

### CPC+ CQMs that count for SIM (see Appendix A for full list of CPC+ CQM reporting requirements)

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>Metric Title</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Depression Remission at Twelve Months (OR SIM depression measure above)</td>
<td>NQF 0710 CMS 159v5</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>NQF 0059 CMS 122v5</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018 CMS 165v5</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Safety</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>NQF 0101 CMS 139v5</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol and Other Drug Dependence</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>NQF 0004 CMS 137v5</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder: Tobacco</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>NQF 0028 CMS 138v5</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Breast Cancer Screening (SIM reported via claims)</td>
<td>NQF 2372 CMS 125v5</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Colorectal Cancer Screening (SIM reported via claims)</td>
<td>NQF 0034 CMS 130v5</td>
</tr>
</tbody>
</table>
Summary of Reporting Requirements

Primary vs. Secondary

- Primary measures are the focus areas where SIM aims to move the needle over the course of the initiative. Secondary measures are still important, and can be reported, but practice sites should focus their practice transformation and data quality efforts on the primary measures. Practice sites will make a good faith effort to report on all primary CQMs for SIM.
- If practice sites cannot report a primary CQM in a given quarter, the practice site should select a secondary CQM to report in its place. Practice sites should work with their Clinical Health Information Technology Advisor (CHITA) to report all primary CQMs in future quarters. Practice sites are encouraged to work with their CHITA to report on all SIM CQMs, including the secondary CQMs, over time and should phase them in as appropriate. Additionally, some payers may ask for secondary CQMs as part of their APM contracts with practices, and practices should work with their CHITAs to understand specific payer reporting requirements and submit those for SIM.

Measurement Period

- Practice sites will report using a trailing year measurement period. If this is not possible, practice sites will report using a year-to-date (YTD) measurement period. For more information, please see this guidance: [http://www.practiceinnovationco.org/wp-content/uploads/2017/01/Changing-SIM-CQM-measurement-period.pdf](http://www.practiceinnovationco.org/wp-content/uploads/2017/01/Changing-SIM-CQM-measurement-period.pdf)
- For Q4 reporting, practice sites should submit clinical quality measure data from the full calendar year January 1 – December 31, 2016 (note, trailing year and YTD measurement period are identical for reporting periods ending December 31 of a given year). This annual CQM report will be shared with payers who support your practice.

SIM Practice Sites Participating in CPC+

- Where applicable, CPC+ measures will count for SIM reporting. SIM will require CPC+ practice sites to choose the behavioral health measures within each of the 3 CPC+ reporting groups. CPC+ practices are not required to report any additional CQMs for SIM, unless they do not report the SIM measures within CPC+ reporting groups.
- CPC+ practice sites will report metrics in SPLIT for SIM in addition to any required reporting for CPC+ through the CPC+ submission portal or MIPS submission portal. All SIM participating practice sites, including CPC+ practice sites, will report CQMs quarterly for SIM, which will facilitate their preparations for the annual CPC+ report.
## Appendix A: CPC+ CQM reporting requirements

<table>
<thead>
<tr>
<th>CPC+ eCQM Requirements Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>eCQM Performance Period</strong></td>
</tr>
<tr>
<td><strong>First eCQM Submission Period</strong></td>
</tr>
<tr>
<td><strong>eCQM Version</strong></td>
</tr>
<tr>
<td><strong>eCQM Reporting Method</strong></td>
</tr>
</tbody>
</table>

### CPC+ eCQM Set - 2017 Performance Period

<table>
<thead>
<tr>
<th>CMS ID#</th>
<th>NQF#</th>
<th>Measure Title</th>
<th>Measure Type/Data Source</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report 2 of the Group 1 outcome measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS159v5</td>
<td>0710</td>
<td>Depression Remission at Twelve Months</td>
<td>Outcome/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS165v5</td>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>Outcome/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS122v5</td>
<td>0059</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt; 9%)</td>
<td>Outcome/eCQM</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td><strong>Report 2 of the Group 2 complex care measures:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS156v5</td>
<td>0022</td>
<td>Use of High-Risk Medications in the Elderly</td>
<td>Process/eCQM</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>CMS149v5</td>
<td>N/A</td>
<td>Dementia: Cognitive Assessment</td>
<td>Process/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS139v5</td>
<td>0101</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>Process/eCQM</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>CMS137v5</td>
<td>0004</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>Process/eQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td><strong>Report 5 of the 10 remaining measures (choice of Group 3 and remaining Groups 1 and 2 measures):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS50v5</td>
<td>N/A</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Process/eCQM</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>CMS124v5</td>
<td>0032</td>
<td>Cervical Cancer Screening</td>
<td>Process/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS130v5</td>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
<td>Process/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS131v5</td>
<td>0055</td>
<td>Diabetes: Eye Exam</td>
<td>Process/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS138v5</td>
<td>0028</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Process/eCQM</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS166v5</td>
<td>0052</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>Process/eCQM</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
<tr>
<td>CMS125v5</td>
<td>2372</td>
<td>Breast Cancer Screening</td>
<td>Process/eCQM</td>
<td>Clinical Process/Effectiveness</td>
</tr>
</tbody>
</table>
Changing the SIM CQM measurement period

Summary

- Practice sites and CHITAs trust annual, full calendar year (Jan - Dec) CQM data; this aligns with CPC+ and guidance on most NQF/CMS endorsed standards.
- The ability to “choose” a measurement period varies widely across EHRs used in SIM practices; some EHRs only support year-to-date (YTD) reporting, others only support trailing year reporting, others have more flexible functionality to choose a number of measurement periods.
- Starting in Q1 2017, practice sites will report CQMs using either a trailing year or YTD measurement period; trailing year is preferred and YTD is back-up if trailing year is not possible.
- Practice sites will continue to report quarterly CQM data for SIM; this allows for real-time data to inform QI, for practices to gain experience reporting CQMs in preparation for the annual report, and to identify gaps and issues with CHITAs and remedy prior to “official” full calendar year (Q4) report.
- The Q4 report will serve as the full calendar year (Jan – Dec) report.
- Full calendar year (Jan - Dec) CQM report data will be shared with payers that are supporting the practice site through SIM once annually.
- Practice sites/CHITAs will be able to indicate which approach (YTD or trailing year) they are using when they report CQMs each quarter in SPLIT.

Quarterly (90-day) measurement period

For existing programs (CPC classic, CPC+, MU), ONC certifies CQMs to report according to a full calendar year measurement period (Jan-Dec). Quarterly reporting (90-day measurement period) is not used for any other program. SIM practice sites and CHITAs find the data calculated according to the quarterly measurement period inaccurate, as most (if not all) EHR vendors do not support quarterly reporting. Many EHR vendors clear data from their warehouses in December each year. Practice sites and CHITAs only trust the CQM reports when there is one full year’s worth of data.

Currently SIM practices are reporting data using different measurement periods. In SPLIT, practice sites record if the reported CQMs were generated using both a 90-day measurement period and the standard SIM measure specifications (“standard”). All other combinations of measurement periods and specifications are lumped together as “alternative” with no way to differentiate specification differences more granularly.

Practice representatives are concerned about how the quarterly data will be used (for payment, benchmarks, etc.). The SIM Office will communicate to payers that practice sites are in “good standing,” signifying that practices are reporting CQMs each quarter (among other milestones). The SIM office will only share practice-site CQM data with payers annually using the data entered in Q4 for the Jan 1 - Dec 31 measurement period.
## Alternative options

<table>
<thead>
<tr>
<th><strong>Preferred approach</strong></th>
<th>“Backup” option - if practices are unable to reporting using trailing year they can report YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trailing year</strong></td>
<td><strong>Year-to-date (YTD)</strong></td>
</tr>
<tr>
<td>365-day measurement period immediately prior to the last day of the current reporting quarter</td>
<td>Measurement period is from the start of the calendar year to the last day of the current reporting quarter</td>
</tr>
<tr>
<td>For SIM year 1 Q4, report 1/1/16 – 12/31/16</td>
<td></td>
</tr>
<tr>
<td>For SIM year 2 Q1, report 4/1/16 – 3/31/17</td>
<td></td>
</tr>
<tr>
<td><strong>Pros:</strong> This approach is more predictive of end of year performance and matches the measure stewards’ intent. Cons: This approach is slow to respond to process improvement and most EHRs don’t provide this function.</td>
<td><strong>Pros:</strong> Most EHRs can report utilizing this approach in a MU dashboard. Cons: Denominators change during the year (getting larger as the year goes on), and variable lookback causes nonsensical results for several of the CQMs. Most practices don’t trust the data until at least Q3.</td>
</tr>
</tbody>
</table>

Trailing year measurement periods are more reflective of true performance, stable over time, and trusted by practice representatives and CHITAs than 90-day and YTD measurement periods. Trailing year and YTD are both easier to pull reports from EHRs than 90-day reports.

There is mixed feedback about which approach is best from a quality improvement (QI) perspective. While there is some indication that YTD is easier to report, trailing year may be more meaningful for practices. However, some EHR vendors only support YTD reporting while other vendors only support trailing year reporting. Therefore, the SIM Office needs to allow for flexibility in practice CQM reporting.

### Timing

Practice sites will start using the new measurement periods starting for the Q1 2017 period ending March 31, 2017 (due April 30, 2017). That will allow for more accurate, trusted data for cohort 1 practice sites during their full second year of participation in SIM. Cohort 1 practice sites will report a full calendar year of CQM data for their first year of participation in SIM (January – December 2016) as part of the Q4 report (due Jan. 31, 2017). This 2016 annual data will be shared with payers. Payers will be informed of the issues associated with measurement periods for year 1 data and apprised of the SIM approach for moving forward. Cohort 2 will start CQM reporting according to this new strategy.
Continued quarterly reporting

Practices need a *leading indicator* of year-end CQM performance so that they can assess the results of QI efforts. A good leading indicator should predict performance at the end of the year when CQMs are submitted to payers (and CMMI).

Quarterly CQM reporting is not very effective as the *sole* QI tool. Practices are encouraged to use data to manage their patient populations, guide QI activities, and track performance. SIM, like CPC classic, supports practices in optimizing patient registries (i.e. diabetes, depression, preventive services) and coaches practices how to use plan-do-study-act reviews on actionable data.

SIM will maintain quarterly CQM reporting for practices. The goal is to work toward data quality and increase trust in the data. CHITAs and practice representatives should use the quarterly reports to “practice” reporting the CQMs, identify any gaps or issues, and shore up quality of the quarterly data in preparation for the annual report shared with payers.

Quarterly CQM reporting will also help prepare practices for the federal quality payment plan (QPP) that has been introduced through the MACRA final rule. While calendar year (Jan – Dec) is the measurement period for QPP, CMS is allowing for a minimum 90-day report. It is unclear how CMS is handling measurement period for partial year reporting. Quarterly CQM reporting for SIM will allow practices to improve data quality for annual QPP and CPC+ reporting for practices participating in both initiatives.

**How CQMs will be used/shared**

The primary purpose of reporting CQMs is to provide real-time, actionable data for practice QI processes. Additionally, full calendar year CQM data will be provided to payers. Payers are applying organization-specific payment model(s) and establishing their own agreements with participating SIM practices. The use of CQM data in value-based payment arrangements will be determined by each payer individually, and outlined in the agreement with the practice. Lastly, quarterly CQM data will be included in quarterly reports to CMMI and included in the evaluation. Quarterly reporting will allow practices and CHITAs to improve data quality and create trust in the data.

The SIM Office will report to payers that practice sites are in “good standing” for SIM, which includes completing quarterly CQM reporting requirements (among other milestones). CQM data will only be shared with payers for the practices they support once annually.

**Operational considerations**

Changing the measurement period and allowing for practice sites to report using two different approaches has operational implications. Practice sites and/or CHITAs will need the ability to indicate which measurement period they are using when reporting CQMs. The University of Colorado and DARTNet are refining ways to collect and report different measurement periods for ENSW and TCPI that can be applied to SIM in early 2017.

An addendum will be added to the cohort 1 practice agreement, which states that individual practice site CQMs will be reported to the payers that support them on an annual basis. This will also be built into cohort 2 practice agreements and the RFA.
SIM NPI and Taxonomy Codes Update and Attribution Fact Sheet

How are your individual NPI number and taxonomy code used in SIM?

Your **individual National Provider Identifier (NPI)** plays a significant role in how SIM identifies your patients, and their corresponding claims data, in the Colorado All Payer Claims Database (APCD). The process of connecting you with your patients, which is called attribution, is outlined for SIM purposes in this document. Providing complete and accurate NPIs allows SIM to calculate cost and utilization data which is reported back to your practice site.

APCD claims data from each patient’s insurance plan(s) are attributed to SIM providers and used to calculate cost and utilization reports for each SIM practice site. This is done by matching individual NPIs submitted by your practice in the SIM practice roster with the individual NPI for the healthcare provider found in APCD claims.

Another important provider database descriptor is your **taxonomy code** associated with your individual NPI in the **National Plan and Provider Enumeration System (NPPES)**. This code associates you with the specialty most applicable to your professional status. NPPES is an important tool used by many health plans, credentialing entities and government programs for attribution. The fastest way to update and confirm NPPES information is to go online.

In the current SIM practice roster **individual NPIs and taxonomy codes** are incorrect, out of date or associated with a provider type that might not be included in the SIM attribution model. Your **individual NPI** is a unique, one-time and sustained identifier, so it shouldn’t change over time unless your profession changes (e.g., a practicing physician’s assistant attends medical school and becomes a doctor).

However, your **taxonomy code** will change. For example, a medical resident’s **taxonomy code** reflects his or her status as a “Student in an Organized Health Care Education/Training Program” (390200000X). Once residency is completed, the **taxonomy code** should be changed to reflect specialty, e.g. Family Medicine (207Q00000X). Taxonomy codes are used in the SIM attribution process to identify SIM-designated primary care providers, a category that includes the following: physicians, nurse practitioners, physician assistants, clinical nurse specialists. SIM primary care specialties include: family medicine, internal medicine, pediatrics, and geriatric medicine.

Patients are attributed to obstetrics/gynecology (OB/GYN) in a secondary attribution run if they were not first attributed to a primary care provider.

For SIM purposes, if your **individual NPI or taxonomy code** is incorrect or out-of-date, your patients might be attributed to another provider by the initiative’s attribution process. With zero or a limited
number of attributed patients, the SIM program cannot generate accurate cost and utilization reports for your practice site.

What can you do to correct your individual NPIs and taxonomy codes?

Some SIM practice rosters only include individual NPIs for a portion of providers in the practice site. If your SIM practice roster only includes four NPIs and your practice site has eight providers, there will be an incomplete number of patients attributed to your practice and incomplete cost and utilization data reported back to your practice site.

Additionally, updating NPPES information to reflect current provider status improves the accuracy of SIM’s attribution and thereby the cost and utilization reports delivered to practices. On a broader note, NPPES is viewed as a primary source for provider status and information. Keeping NPPES regularly updated helps to ensure accuracy in all sorts of professional databases.

Why update your group or organization NPIs for SIM?

When an individual provider NPI is not available on a claim, the provider’s group or organization NPI can be used to determine attribution. The group or organization NPI also provides insight into the SIM practice site unit of analysis. Since SIM is working with practice sites versus entire practice organizations, the group or organization NPI helps determine which providers belong to your practice site.

The group or organization NPI also allows patients to be attributed to SIM participating clinics or centers that operate under prospective payments such as: federally-qualified health centers (FQHCs), rural health, community health, public health (federal, state or local), and student health.

If your practice bills Medicare or Medicaid, you have a group or organization NPI and group or organization taxonomy data in NPPES. Groups should update their information in the same fashion as individual practitioners on this site: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Tips for updating your SIM practice roster:

- Include individual NPIs for all providers at your practice site to achieve the most accurate attribution and most complete cost and utilization reports.
- Refer to taxonomy code table linked in the SIM practice roster to update your taxonomy codes.
- Update your information in the NPPES.
SIM Attribution Model Summary

- The SIM Attribution Model is the process for associating individuals in the APCD with SIM primary care providers.
- Attribution is necessary for identifying patients who are affected by SIM efforts, creating SIM practice level cost and utilizations reports, and evaluation purposes.
- For an individual to be eligible for the initial SIM attribution population, he or she must have medical insurance coverage/eligibility for at least one month during the preceding 24-month period (24-month lookback period).
- Individual lines within each claim are rolled together as “one visit”. Subsequent visits with the same provider on the same day are not counted.
- Services must be furnished by a provider associated with one or more SIM identified primary care taxonomy codes. A list of taxonomy codes is linked in the SIM practice roster for reference.
- Claims must include SIM identified place-of-service codes at SIM-qualified primary care service locations, which include physician offices, hospital ambulatory clinics, individual homes, nursing facilities, federally-qualified health centers (FQHCs), rural health clinics, community health centers, and community mental health centers.
- Tie-breaker: If multiple service providers have the same quantity of claims with an individual, the tie is broken by assigning an individual to the primary care provider who the patient has visited most recently.
- Six steps are completed using the initial SIM attribution population, following the outline below.
  - For runs 1-4, professional claim types are considered.
  - For runs 5-6, outpatient type claims are considered.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Engage claims for the most recent activity period using provider NPIs. Remove the resulting attributed individuals from further processing.</td>
</tr>
<tr>
<td>Step 2</td>
<td>Engage claims for the lookback activity period using provider NPIs. Remove the resulting attributed individuals from further processing.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Engage claims for the most recent activity period with specified women’s health or OB/GYN providers and students in an organized healthcare education/training program using provider NPIs. Remove the resulting attributed individuals from further processing.</td>
</tr>
<tr>
<td>Step 4</td>
<td>Engage claims for the lookback activity period with specified women’s health or OB/GYN providers and students in an organized healthcare education/training program using provider NPIs. Remove the resulting attributed individuals from further processing.</td>
</tr>
<tr>
<td>Step 5</td>
<td>Engage claims for the most recent activity period using group or organization NPIs to attribute individuals to specific clinics or centers, including FQHCs, rural health, community health, public health (federal, state, or local), primary care, and student health. Remove the resulting attributed individuals from further processing.</td>
</tr>
<tr>
<td>Step 6</td>
<td>Engage claims for the lookback activity period using group or organization NPIs to attribute individuals to specific clinic or centers, including FQHCs, rural health, community health, public health (federal, state, or local), primary care, and student health. Remove the resulting attributed individuals from further processing.</td>
</tr>
</tbody>
</table>
WHERE TO START?

1. **Patient Population**
   - (*Active* Patient Panel)
   - **POSITIVE BH/SUD**
   - **Negatively Impacted Population**

WHERE TO START?

1. **Patient Population**
   - (*Active* Patient Panel)
   - **POSITIVE BH/SUD**
   - **NEGATIVE EFFECTS**

**BUILD INFRASTRUCTURE**

**BB1 - Engaged Leadership**
- Year 1: Establish agreements with payers, set up budget, QI team, champion attends CLS, set vision for behavioral health (BH) integration and pathway

**BB4 - Team-Based Care**
- Year 2: Workflows for three CQMs (at least 1BH)

**BB5 - Partnership with Patients**
- Year 1: Establish PFAC
- Year 2: Shared decision-making aids and self-management support tools

**BB8, BB9 and BB10 - Behavioral Health Issues**
- Year 1: Start building infrastructure to address BH
- Year 2: Develop collaborative care agreements with BH providers

**IMPROVE CONTINUITY THROUGH EMPANELMENT**

- **BB3 - Empanel at least 75% of Patient Population**
- **BB7 - Screen up to 90% for BH/SUD**
  - Connect to BH/Community

**BB6 - Risk Stratification**
- Year 2: Risk stratify at least 75% of population

**LOW RISK**
- Prevent Low and Medium Risk patients from becoming High Risk

**HIGH RISK**
- **BB6 - Close at least 75% of High Risk Patients**

**EXPAND and MAINTAIN EFFORTS**

- **ALL PATIENTS**
  - Continue BB1, BB2, BB4, BB5

- **BB6 - High Risk Patients**
  - Year 2: Risk stratify, use data to manage care gaps/track outcomes, develop care plans for 75% of high-risk patients

- **Patients with BH Issues**
  - BB8 - Access to BH Care
  - Year 2: Bi-directional data sharing

- **BB9 - Care Coordination to Reduce Costs and Improve Care**

- **BB10 - BH Referral Pathway with 24/7 EHR Access; Care Plans, Track BH Patient Outcomes**

**COORDINATED and/or INTEGRATED CARE**

- **BUILD INFRASTRUCTURE**
  - **BB2 - Use Data to Drive Change**
    - Year 1: Data, care gaps, CQMs, cost drivers
  - **BB7 - Screen up to 90% for BH/SUD**

**BB3 - Empanel at least 75% of Patient Population**

**BB7 - Screen up to 90% for BH/SUD**
- Connect to BH/Community

**BB6 - Risk Stratification**
- Year 2: Risk stratify at least 75% of population

**STRATEGICALLY MANAGE YOUR POPULATION BY RISK STRATIFYING TO DETERMINE WHO NEEDS ADDITIONAL ATTENTION/SERVICES**

**BUILD COLLABORATIVE AGREEMENTS WITH BEHAVIORAL HEALTH (EITHER ONSITE OR OFFSITE) TO IMPROVE COORDINATION AND MANAGEMENT**

**BUILD INFRASTRUCTURE**

**BB1 - Engaged Leadership**
- Year 1: Establish agreements with payers, set up budget, QI team, champion attends CLS, set vision for behavioral health (BH) integration and pathway

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- Year 1: Establish PFAC
- Year 2: Shared decision-making aids and self-management support tools

**BB8, BB9 and BB10 - Behavioral Health Issues**
- Year 1: Start building infrastructure to address BH
- Year 2: Develop collaborative care agreements with BH providers

**Build/Expand/Maintain Infrastructure**

**Manage Patient Population**

**Manage Risk**

**Achieve Goals**

**SIM Cohort 2 Milestone Algorithm (Overview) Key**

- **Build/Expand/Maintain Infrastructure**
- **Manage Patient Population**
- **Manage Risk**
- **Achieve Goals**

**Improve Quality of Care**
**Reduce Costs**
**Improve Experience for Patients & Healthcare Teams**
SIM Phased Approach Timeline – Year 1
(assumes 9/1/17 start)

Phase 1
BB1.Y1 – Engaged Leadership
1. Establish value-base agreements with payers
2. Complete annual budget
3. Develop QI Team
4. Attend Collaborative Learning Session
5. Set vision for BHI

Phase 2
BB2.Y1 – Use data to drive change
1. Submit CQM’s quarterly
2. Review data quarterly
3. Identify opportunities for CQM improvement
4. Use data aggregation tool to review cost/utilization data

BB4.Y1 – Provide Team-based care
1. Assess baseline team relationship
2. Develop job descriptions
3. Identify/implement team-base care strategy

BB5.Y1 – Build patient partnerships
1. Identify 3 conditions (at least one BH) appropriate for decision aids/SMS (1 for peds)
2. Select evidence-based decision aids/SMS tools for identified conditions
3. Establish PFAC/meets quarterly

Phase 3
BB3.Y1 – Engage 75% of patient population
1. Assess panel and assign PCP/care team to 75% of patients
2. Review attribution lists monthly
3. Validate PCP/care team assignments

BB7.Y1 – Screen for BH/SUD and link to resources
1. Identify BH resources (work with RHC)
2. Identify screening tools for two BH measures
3. Document process for connecting patients/families with BH resources

Phase 4
BB6.Y1 – Risk stratify/actively manage patients
1. Identify risk stratification methodology (Adult only)
2. Identify care gaps

Phase 5
BB8.Y1 – Provide prompt access
1. 24/7 EHR access
2. Assess referral pathways for after hours BH support
3. Identify data sources and technology for bi-directional data sharing

BB9.Y1 – Comprehensive care coordination
1. Identify total cost of care
2. Implement policy for timely follow up for ED and hospital admissions

BB10.Y1 – Provide fully integrated BH for whole person care
1. Use identified referral pathways for BH needs
2. Measure and track BH outcomes
3. Develop care plans to manage BH conditions

Note: The order of milestones and activities may vary based on individual practice circumstances. Refer to Implementation Guide for more information on each milestone and related activity.
SIM Phased Approach Timeline – Year 2
(assumes 9/1/17 start)

**Phase 6**

**BB1.Y2 - Engaged Leadership**
1. Allocate appropriate resources to complete QI work
2. Design plans to evaluate effects of value-based payments

**BB2.Y2 - Use data to drive change**
1. Review CQM data
2. Develop process for providing performance feedback to providers
3. Conduct regular QI activities based on CQM’s

**BB4.Y2 - Provide team-based care**
1. Re-evaluate team relationships
2. Develop protocols for shared workflows (3 CQM’s with at least one BH measure)
3. Review roles/responsibilities for team-based care activities

**BB5.Y2 - Build patient partnerships**
1. Identify patients eligible for decision aids of SMS tools
2. Implement decision aids/SMS tools and establish protocol and workflow
3. Track/evaluate use of decision aids or SMS tools
4. Use PFAC to evaluate care experience

**Phase 7**

**BB3.Y2 - Empanel 75% of patient population**
1. Maintain 75% empanelment of patients with PCP/care teams
2. Develop policies to support empanelment

**BB7.Y2 – Screen for BH/SUD and link to resources**
1. Screen 50% of patients for BH conditions
2. Assess community resources to assist patients with social needs (work with RHC)
3. Connect 50% of patients with BH needs to resources

**BB6.Y2 – Risk stratify/actively manage patients**
1. Risk stratify 75% of empaneled patients (adult only)
2. Document care plan for 75% of high-risk patients
3. Implement care gap management and track outcomes
4. Embed care plan into EHR

**Phase 8**

**BB8.Y2 – Provide prompt access**
1. Establish collaborative agreement with at least one BH provider
2. Develop plan for bi-directional data sharing with BH provider

**BB9.Y2 – Comprehensive care coordination**
1. Contact 50% of patients/families within 7 days of hospitalization/ED visit, including medication reconciliation
2. Identify cost drivers for patients with BH condition
3. Create and report measurement to assess and guide improvement on at least one of the following: A) notification of ED visit, B) medication reconciliation within 72 hours, C) Notification of admission and clinical information exchange at time of admission, D) information exchange between primary care and specialty care related to referrals

**BB10.Y2 – Provide fully integrated BH for whole person care**
1. Measure and track patient BH outcomes
2. Document and implement protocols to identify/manage care for high-risk BH populations
3. Identify/implement at least two opportunities to adjust protocols to improve BH health status of patients
4. Demonstrate advanced access to BH services (see milestones for specifics)

Note: The order of milestones and activities may vary based on individual practice circumstances. Refer to Implementation Guide for more information on each milestone and related activity.

**Abbreviations**
- BH: behavioral health
- BHI: behavioral health integration
- CQM: clinical quality measure
- ED: emergency department
- EHR: electronic health record
- PFAC: patient family advisory council
- PCP: primary care provider
- QI: quality improvement
- SMS: self-management support
- SUD: substance use disorder
<table>
<thead>
<tr>
<th>Building Block</th>
<th>Year</th>
<th>Milestone #</th>
<th>Milestone</th>
<th>Practice Attestation Anchor:</th>
<th>Practice Facilitator Attestation Methodology:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>Practice establishes agreement(s) with payer(s) covering at least 150 patients.</td>
<td>Attest to value-based agreement(s) with one or more payers that cover at least 150 patients attributed to the practice site. If not, provide reasons beyond the practice’s control why this hasn’t been possible.</td>
<td>Confirm such an agreement or agreements exist.</td>
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<td></td>
<td>1</td>
<td>2</td>
<td>Practice has completed an annual budget that includes SIM revenue and planned expenses.</td>
<td>Attest to the development of a current budget. If the practice has received alternative payments from payers, the budget should include those revenues and planned expenses to meet contract deliverables.</td>
<td>PF confirms that a budget as described exists at whatever level is appropriate for the practice (practice level or system level). Details of the budget do not need to be reviewed.</td>
</tr>
<tr>
<td>Building Block 1</td>
<td>1</td>
<td>3</td>
<td>Practice develops quality improvement (QI) team and meets monthly.</td>
<td>Document at least monthly meetings through meeting agendas and/or minutes.</td>
<td>Confirm and document improvement team meetings in monthly field notes. Attest if in your opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td></td>
<td>1</td>
<td>4</td>
<td>Practice leadership is present at meetings and clinical champion attends collaborative learning sessions (CLS).</td>
<td>Two representatives are required to attend and sign in at CLS. CPC+ practices may substitute CPC+ CLS, but are also encouraged to participate in SIM CLS.</td>
<td>CLS participation will be monitored separately by the University of Colorado for SIM practices. CPC+ practices not attending SIM CLS should attest to attending CPC+ CLS.</td>
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<tr>
<td></td>
<td>1</td>
<td>5</td>
<td>Practice has vision for behavioral health integration and has identified a pathway for behavioral health transformation signed by leadership.</td>
<td>Produce documentation of a vision statement for behavioral health transformation that includes their selected pathway for behavioral health transformation. This can include such things as plans for full integration, improved coordination through collaborative care, use of telehealth, collaboration agreements with behavioral health entities, etc., as appropriate.</td>
<td>Confirm that a vision statement exists that includes their planned pathway for behavioral health transformation. This should be documented and shared across the practice and with the PF/CHITA/RHC.</td>
</tr>
<tr>
<td>Building Block 2</td>
<td>1</td>
<td>1</td>
<td>Practice successfully submits CQMs quarterly.</td>
<td>Selected group of CQMs submitted quarterly to SIM.</td>
<td>This will be monitored through submission of CQMs through the Shared Practice Learning and Improvement Tool (SPLIT).</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>Practice reviews data with practice facilitator (PF)/clinical health information technology advisor (CHITA) quarterly.</td>
<td>Show evidence that clinical quality measures were reviewed with a PF or CHITA at least every 3 months. This could include documentation in improvement team agendas or meeting minutes.</td>
<td>Document in PF and CHITA monthly field notes and attest if practice meets the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>Practice begins using model for improvement and has identified opportunities for improvement using CQM data.</td>
<td>Document through minutes of improvement team meetings.</td>
<td>Document in monthly field notes and attest if practice meets the milestone as described in the anchor statement.</td>
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<tr>
<td></td>
<td>1</td>
<td>4</td>
<td>Practice begins using a data aggregation tool provided by SIM to review cost and utilization data.</td>
<td>Demonstrate through attestation of use of a tool that provides cost and utilization data, such as Medicaid’s Statewide Data Analytics Contractor (SDAC), Stratus, QRUR reports from Medicare, etc.</td>
<td>Attest if practice is learning to review and use a utilization aggregation tool. Document in monthly field notes.</td>
</tr>
<tr>
<td>Building Block</td>
<td>3</td>
<td>1</td>
<td>Practice has assessed patient panel and assigned primary care providers/care teams to 75% of patient population.</td>
<td>Attest that the practice has empaneled at least 75% of active patients to PCPs and/or care teams and be prepared to present data supporting this.</td>
<td>Confirm the empanelment process used and attest if the practice has accomplished 75% empanelment.</td>
</tr>
<tr>
<td>Building Block</td>
<td>4</td>
<td>1</td>
<td>Practice reviews payer attribution lists monthly.</td>
<td>Attest that payer attribution lists are reviewed by someone at the practice or organization on a monthly basis.</td>
<td>PF can attest if practice meets the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>Building Block</td>
<td>3</td>
<td>2</td>
<td>Practice designs and implements process for validating primary care provider/care team assignment with patients.</td>
<td>Attest to having a process for assigning patients to primary care providers or care teams and validating those assignments on an ongoing basis.</td>
<td>Confirm practice has implemented a process of assigning patients to PCPs/care teams. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>Building Block</td>
<td>7</td>
<td>1</td>
<td>Practice uses established tool to assess baseline team relationships.</td>
<td>Attest that team relationships were assessed and reviewed. Examples of relationship tools could include review of the Medical Home Practice Monitor and the Clinician and Staff Experience Survey, both collected as part of the SIM Assessments.</td>
<td>Confirm review with the practice or practice’s quality improvement team of the results of the Medical Home Practice Monitor and the Clinician and Staff Experience Survey, plus any other similar tools the practice site may have used for this purpose.</td>
</tr>
<tr>
<td>Building Block</td>
<td>4</td>
<td>2</td>
<td>Practice has written job descriptions, including clear roles and responsibilities.</td>
<td>Produce written job descriptions for at least two roles in the practice (i.e. front desk, MA, RN, etc.) and attest that others are in place.</td>
<td>Confirm review of at least two job descriptions, with practice confirmation that others are in place.</td>
</tr>
<tr>
<td>Building Block</td>
<td>7</td>
<td>1</td>
<td>Practice identifies and implements a team-based care strategy (team huddle, collaborative care planning).</td>
<td>Attest that at least one of the following team based care strategies are in routine use as outlined below: - <strong>Team huddle</strong>: occur at least once a week, involve more than one role on the team and have some form of documentation (i.e. written scripts, standing agenda items for huddles, huddle checklists, EHR fields for virtual huddles, written procedures or instructions, etc.) - <strong>Collaborative care planning</strong>: occur at least quarterly, include two or more team members (physician, BH provider, care manager, nursing, social worker, etc.) and have summary of the plan that includes patient goals within the patients’ records.</td>
<td>Confirm practice implementation of team-based care strategies. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>Building Block</td>
<td>7</td>
<td>2</td>
<td>Practice identifies behavioral health resources for patients/families, including support from SIM participating health plans and Regional Health Connectors (RHCs).</td>
<td>Attest to having assessed and identified local behavioral health resources appropriate for the practice’s patient population.</td>
<td>Confirm practice effort to identify appropriate local behavioral health resources. Attest if in PF opinion the practice has fully accomplished the milestone.</td>
</tr>
<tr>
<td>Building Block</td>
<td>7</td>
<td>3</td>
<td>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.</td>
<td>Show the tool(s) used to screen for depression, maternal depression, developmental disorders, tobacco use, unhealthy alcohol use, and/or other substance use disorder. Produce a measure showing that at least 25% of targeted patients were screened with the tool.</td>
<td>Confirm practice implementation of a screening tool. Attest if in PF opinion the practice site has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>Building Block</td>
<td>7</td>
<td>3</td>
<td>Practice has documented process for connecting patients/families with behavioral health resources (from screening), including standing orders and or/protocols and follow-up.</td>
<td>Produce documentation of the standing orders or protocols.</td>
<td>Confirm practice site implementation of standing orders or protocols. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.</td>
</tr>
<tr>
<td>Building Block</td>
<td>Year</td>
<td>Milestone</td>
<td>Description</td>
<td>Confirmation</td>
<td>Attestation</td>
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<tr>
<td>1</td>
<td>2</td>
<td>1</td>
<td>Leadership allocates appropriate resources to complete QI work.</td>
<td>Document ongoing, regular (at least monthly) quality improvement team meetings as in BB1.Y1.3 and show how resources have been allocated to complete QI work.</td>
<td>Confirm ongoing, regular QI team meetings are occurring and document this in monthly field notes. Attest if in PF opinion the practice has allocated sufficient resources for the QI work, including engagement of adequate practice site clinicians and staff in the process.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>Practice designs plan to evaluate impact of value-based payment agreements.</td>
<td>Demonstrate how the practice uses and assesses the impact of value-based payments.</td>
<td>Confirm practice development and implementation of a plan. Attest if the practice site has a plan in place and has evaluated the impact of their value-based payments. Document if barriers have prevented value-based payment agreements from being developed.</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Practice reviews CQM data to inform rapid cycle improvement processes.</td>
<td>Document the use CQM data in ongoing quality improvement efforts to improve care, such as through improvement team minutes.</td>
<td>Documentation in monthly PF and CHITA field notes. PF can attest if practice meets the milestone by specifically using CQM data in QI efforts.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>Practice develops processes for providing performance feedback to providers, including CQM, cost, and utilization data.</td>
<td>Document CQM, cost, and utilization data being tracked and process for sharing with providers.</td>
<td>Attest if there is evidence that performance feedback is provided to providers.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
<td>Practice conducts regular PDSA/QI activities on identified CQMs.</td>
<td>Document use of data for targeted CQMs as part of ongoing, regular QI activities through improvement team minutes.</td>
<td>Document in monthly PF and CHITA field notes. PF can attest if practice QI efforts specifically use CQM data.</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Practice maintains 75% empanelment of patients with provider/care teams.</td>
<td>Document process for regularly monitoring and adjusting empanelment and run report to demonstrate 75% of active patients are empaneled.</td>
<td>Confirm empanelment process. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage.</td>
<td>Document policies for these aspects of empanelment (which ideally should be part of the process developed in year 1).</td>
<td>Confirms practice site has implemented policies to support empanelment. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>Practice reevaluates team relationship using tool from Year 1.</td>
<td>Repeat assessment and discussion of team relationships, as described for year 1.</td>
<td>Confirm review with the practice or practice site’s quality improvement team of the results of the Medical Home Practice Monitor and Clinician and Staff Experience Survey, plus any other similar tools the practice may have used for this purpose, including comparing to baseline results.</td>
<td></td>
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<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure).</td>
<td>Demonstrate protocols and workflows related to the three chosen quality measures.</td>
<td>Confirm practice implementation of protocols and workflows related to three chosen quality measures. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
<td>Practice reviews roles/responsibilities for team-based care activities to ensure accountability for various tasks assigned.</td>
<td>Document roles and responsibilities for the various team-based activities.</td>
<td>Confirm implementation of screening. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>Building Block 7</td>
<td>2</td>
<td>1</td>
<td>50% of patients are screened for behavioral health conditions.</td>
<td>Demonstrate that at least 50% of patients are screened for key behavioral health conditions, chosen as appropriate for the patient population.</td>
<td>Confirm review of practice data to assure that at least 50% of patients are screened for key behavioral conditions.</td>
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<td>2</td>
<td>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).</td>
<td>Provide documentation of the assessment of community resources to assist patients with social needs. This can include the use of formal external assessments of such resources.</td>
<td>Confirm practice assessment of community resources. RHC may be able to assist. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.</td>
</tr>
<tr>
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<td>2</td>
<td>3</td>
<td>50% of patients identified with a behavioral health need are connected to resource.</td>
<td>Provide data indicating that 50% of patients identified with behavioral health needs are connected to resources; can include resources within or outside the practice.</td>
<td>Review practice site's data to assure that at least 50% of patients with behavioral health needs are connected to resources. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.</td>
</tr>
</tbody>
</table>

**Additionally Required Milestones for SIM-Only Practice Sites include achievement of at least two of Building Blocks (BB) 5, 6, 8, 9 OR 10 in Year 2.**

**Additionally Required Milestones for SIM/CPC+ Practice Sites include achievement of Building Blocks (BB) 8, 9 AND 10 in Year 1 and Year 2.**

<table>
<thead>
<tr>
<th>Building Block 5</th>
<th>1</th>
<th>1</th>
<th>Practice evaluates patient population to identify one preference-sensitive condition that is appropriate for decision aids or self-management support tools.</th>
<th>Indicate the condition(s) chosen for this activity.</th>
<th>Confirm the practice has chosen three conditions and document this in field notes, along with any changes or additions through the initiative.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>Practice identifies and selects evidence-based decision aids or self-management support tools for identified conditions.</td>
<td>Describe the selected decision aids or self-management tools.</td>
<td>Confirm practice implementation of decision aids or self-management tools. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>Practice has established a Patient and Family Advisory Council (PFAC) and meets at least quarterly.</td>
<td>Provide minutes or other records of quarterly PFAC meetings and documentation of decisions made based on PFAC input.</td>
<td>Confirm practice implementation of PFAC meetings. Periodically review minutes or other records of PFAC meetings for discussion in quality improvement team meetings. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>Practice identifies patients and families eligible for selected decision aids or self-management support tools.</td>
<td>Attest that process for targeting patients for decision aids or self-management support has been developed and implemented.</td>
<td>Confirm practice has identified patients eligible for selected decision aids or self-management support tools. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2</td>
<td>2</td>
<td>Practice implements decision aids or self-management support tools and establishes protocol and workflow for use.</td>
<td>Attest that workflow for implementation of decision aids or self-management support tools has been developed and implemented, with documentation of use as in BB5.12.3.</td>
<td>Confirm practice development of workflow. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td></td>
<td>2</td>
<td>3</td>
<td>Practice develops process for tracking and evaluating use of decision aids or self-management support tools.</td>
<td>Describe processes for tracking the use and impact of shared decision making tools and provide data documenting their use.</td>
<td>Confirm practice implementation of process. Attest if in PF opinion the practice site has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2</td>
<td>4</td>
<td>Practice uses PFAC to evaluate care experience.</td>
<td>Document PFAC suggestions used to evaluate and improve patient experience of care through PFAC and or improvement team minutes.</td>
<td>Confirm review of PFAC minutes or other records of meetings and identify how practice is working on patient experience of care. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
</tr>
<tr>
<td>Building Block 6</td>
<td>1 2</td>
<td>Practice identifies and documents a risk stratification methodology. (Recommended, but not required for pediatric practices.)</td>
<td>Document a chosen risk stratification methodology that specifically fits the needs and resources of your practice. Note the potential alignment with activities described for BB10.</td>
<td>Confirm practice identification of a risk stratification methodology. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.</td>
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<td>Building Block 8</td>
<td>1 2</td>
<td>Practice identifies strategy to identify care gaps (e.g. patient registry, data aggregation tool) and prioritize high-risk patients/families.</td>
<td>Attest to the development of a strategy and workflow for identification of care gaps for high risk patients and families, including use of a patient registry, data aggregation tool, or similar process.</td>
<td>Confirm practice implementation of strategy and workflow. Attest if in PF opinion the practice has fully accomplished the milestone as described in the milestone or anchor statement.</td>
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<td>2 1</td>
<td>75% of empaneled patients are risk-stratified. (Recommended, but not required for pediatric practices)</td>
<td>Provide data indicating that this target has been met.</td>
<td>Review practice data and attest if target is met.</td>
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<td>2 2</td>
<td>75% of high-risk patients/families have a documented care plan.</td>
<td>Provide data indicating the presence of the care plan developed in BB10.Y1.3 for 75% of high risk patients.</td>
<td>Review practice data and attest if target is met.</td>
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<tr>
<td>2 3</td>
<td>Practice implements proactive care gap management and tracks outcomes.</td>
<td>Attest to the implementation of a process for providing care management for high risk patients and the outcomes of the care management.</td>
<td>Confirm practice implementation of a process for providing care management for high-risk patients and the outcomes. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<tr>
<td>2 4</td>
<td>Practice embeds care plan template in EHR.</td>
<td>Demonstrate that the care plan is embedded in the EHR, or show another method for tracking and sharing the care plan if that is not possible</td>
<td>Confirm practice implementation of an embedded care plan in EHR or another method for tracking the care plan. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>1 1</td>
<td>Practice has representative with EHR access available 24 hours, 7 days per week.</td>
<td>Attest or provide documentation that after hours call providers have access to the practice’s own EHR and patient records.</td>
<td>Confirm that this milestone has been met. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>1 2</td>
<td>Practice performs an assessment of referral pathways and available after- hours support for behavioral health, working with RHCs when possible.</td>
<td>Attest to development of a pathway for at least one type of referral to behavioral health (preferably one that fits with the reported CQMs and other practice QI efforts), including mechanism for after-hours support.</td>
<td>Confirm practice development of a pathway for at least one type of referral to behavioral health. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>1 3</td>
<td>Practice identifies data sources and technology necessary for bi-directional data sharing.</td>
<td>Describe what is needed to accomplish bi-directional data sharing with behavioral health partners, whether integrated or separate from the practice.</td>
<td>Confirm that the practice has explored data sources and technology for bi-directional data sharing with behavioral health partners.</td>
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<td>2 1</td>
<td>Practice has established a collaborative agreement with at least one behavioral health provider.</td>
<td>Document the collaborative agreement.</td>
<td>Confirm the development of at least one collaborative agreement. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2 2</td>
<td>Practice develops plan for bi-directional data sharing with behavioral health provider.</td>
<td>Attest to having a plan for bi-directional data sharing. Explain barriers if unable to implement plan at this time.</td>
<td>Attest if a plan for bi-directional data sharing has been developed.</td>
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<td>1 1</td>
<td>Practice can identify total cost of care for patient panel, and subset of patients with behavioral health condition.</td>
<td>Attest to use of cost and utilization tool to identify the cost of care for all patients and for those with at least one specific behavioral health condition. Document use of this data in improvement team minutes.</td>
<td>Confirm practice use of cost and utilization tools. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>1 2</td>
<td>Practice identifies and implements policy and procedures that include timely follow-up for emergency department (ED) and hospital admissions.</td>
<td>Attest to implementation of policies and procedures for transitions of care for hospitalizations and ED visits.</td>
<td>Confirm practice implementation of policies and procedures for transitions of care for hospitalization and ED visits. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<tr>
<td>Building Block 9</td>
<td>2 1</td>
<td>Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation.</td>
<td>Provide data demonstrating that at least 50% of patients are contacted within 7 days of hospitalization or ED visit.</td>
<td>Review practice data regarding contact of patients after hospitalization or ED visit. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2 2</td>
<td>Practice identifies cost drivers for patients with behavioral health condition(s) and incorporates in QI processes.</td>
<td>Document QI process for improving cost of care for at least one behavioral health condition through improvement team minutes.</td>
<td>Assist practice in QI process to improve cost of care for at least one behavioral health condition. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2 3</td>
<td>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 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.</td>
<td>Document the measure and the results of the improvement process through improvement team minutes.</td>
<td>Confirm practice work to measure improvement process. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<tr>
<td>Building Block 10</td>
<td>1</td>
<td>1</td>
<td>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).</td>
<td>Attest to development and implementation of referral pathway.</td>
<td>Confirm practice implementation of a referral pathway for behavioral health needs. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>1</td>
<td>2</td>
<td>Practice develops a plan to systematically measure and track patient behavioral health outcomes.</td>
<td>Attest to development of plan to systematically measure and track patient behavioral health outcomes for key conditions targeted by the practice.</td>
<td>Confirm practice reporting of chosen measures and outcomes and plan for extracting and tracking data. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>1</td>
<td>3</td>
<td>Practice develops care plans that include patient actions to manage behavioral health conditions.</td>
<td>Provide examples and evidence of ongoing use of the care plans.</td>
<td>Confirm practice use of care plans. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2</td>
<td>1</td>
<td>Practice systematically measures and tracks patient behavioral health outcomes.</td>
<td>Provide data demonstrating systematic tracking of patient behavioral health outcomes for key condition(s) targeted by the practice.</td>
<td>Confirm presence of tracking data. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>2</td>
<td>Practice documents and implements protocols to identify and manage care for high-risk behavioral health populations.</td>
<td>Provide evidence of implementation of care management for conditions chosen as relevant for practice's patient population. Note that this aligns with BB6.Y1.1, BB6.Y1.2, and BB6.Y2.3.</td>
<td>Confirm practice implementation of care management for chosen conditions. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement.</td>
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<td>3</td>
<td>Practice identifies and implements at least two opportunities to adjust its protocols to improve behavioral health status of patients.</td>
<td>Document how protocols have been adjusted to improve behavioral health status through improvement team minutes.</td>
<td>Confirm practice effort to improve protocols. Attest if in PF opinion the practice has accomplished the milestone in the anchor statement.</td>
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<td>2</td>
<td>4</td>
<td>Practice demonstrates advanced access to behavioral health services.</td>
<td>Attest to and be prepared to demonstrate full implementation (as described in the Implementation Guide) of either: 1) one or more integrated behavioral clinicians; or 2) another fully developed model for identifying, treating, and monitoring patient behavioral issues that includes a closely coordinated relationship with external behavioral health resources.</td>
<td>Confirm practice implementation of advanced access to behavioral health services. Attest if in PF opinion the practice has fully accomplished the milestone as described in the anchor statement and the Implementation Guide.</td>
</tr>
</tbody>
</table>

**PLEASE NOTE:**

**Status Rating Categories:**
1) Not started at this time; 2) Just beginning, minor progress; 3) Actively addressing, almost completed; 4) Completed, fully implemented across the practice

For milestones BB1.Y1.1 and BB8.Y2.2 will add a rating of: 0) Not possible at this time, with a prompt to provide further explanation of the reason(s) each is not possible.

“Good Standing” is determined by attesting to a “4” rating for at least 75% of the **required** milestones and at least a “3” for all other required milestones.