Implementation Milestone Assessment Tool

California Quality Collaborative

Background and Instructions	
Background	The California Quality Collaborative (CQC) has developed the Implementation Milestone Assessment Tool (IMAT) to help health care practices evaluate their quality improvement (QI) infrastructure and delivery of advanced primary care. The tool is crafted to be completed at the practice level and is a point-in-time snapshot of the practice's capabilities. Practices can use the tool as a starting point for conversations about practice improvement priorities and to track improvements in advanced primary care and QI capabilities over time. CQCs IMAT has been informed by over a decade of experience working to support and strengthen primary care via the CalHIVE improvement collaboratives. Learn more: pbgh.org/initiative/calhive-improvement-collaboratives. Additionally, these efforts include CQC's work with stakeholders across the health care ecosystem to define a shared vision for advanced primary care. More information is available here: pbgh.org/initiative/ca-advanced-primary-care-initiative.
IMAT Milestones	The IMAT includes 16 milestones related to the attributes of Advanced Primary Care.
IMAT Scoring	For each milestone, there are four scoring options. 0 - Not Yet Started: Efforts to implement the capabilities described within the milestone have not yet started. 1 - Planning: Initial planning and/or limited implementation of the capabilities described within the milestone are underway. 2 - Implementing: Broad implementation of the capabilities described in the milestone is ongoing. 3 - Functioning: The capabilities described within the milestone are now functioning and are standard practice.

How to Complete	The assessment should be completed with input from a multi-disciplinary team that is collectively familiar with a broad range of the practice's infrastructure and capabilities. Consider having each team member complete the assessment individually and then meet to discuss the results and agree on a final practice-level score for each milestone. If available, work with an improvement coach or other facilitator to help guide the conversation. Complete the assessment annually or at agreed-upon intervals to assess changes in practice capabilities over time.
Citations	The following resources informed the development of CQC's IMAT: The 10 Building Blocks of High-Performance Primary Care. For a detailed description of the Building Blocks, please refer to ncbi.nlm.nih.gov/pmc/articles/PMC3948764. The Center for Medicare and Medicaid Services, Transforming Clinical Practice Initiative, Practice Assessment Tool 2.0, available here cms.gov/priorities/innovation/files/x/tcpi-primary-pat.pdf The Population Health Management Capabilities Assessment Tool (PhmCAT), developed to support Kaiser Permanente's Population Health Management Initiative. For more information or to download the tool, visit phminitiative.com/phmcat.

Contact **California Quality Collaborative**
cqcinfo@pbgh.org | pbgh.org/cqc

Practice Information	
Date of Assessment	
Practice Name	
Number of Clinicians (physicians and advanced practice providers)	
Number of Patients Served (round to nearest 1,000)	
• **Commercial** - Total number (round to nearest 1,000) - Proportion fee-for-service (e.g., PPO) vs. Managed Care (e.g., HMO)	
• **Medi-Cal (include dual beneficiaries)** - Total number (round to nearest 1,000) - Proportion fee-for-service vs. Managed Care	

• **Medicare** - Total number (round to nearest 1,000) - Proportion fee-for-service vs. Medicare Advantage	
• **Uninsured** - Total number (round to nearest 1,000)	
• **Other (include description)** - Total number (round to nearest 1,000)	
Electronic Medical Record (vendor)	
Population Health Platform (vendor)	
Qualified Health Information Organization (QHIO) or Health Information Exchange (HIE) (vendor)	

Data Exchange Framework - Data Sharing Agreement Signatory (Yes/No)	

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
	Engaged Leadership						
1	Leadership has a vision for high-quality, integrated, equitable care that is championed broadly throughout the practice. There is a strategy and measurable goals in place that relate to that vision.	Practice has no formally defined vision or strategy to achieve high-quality, integrated, equitable care. Leadership is mostly focused on day-to-day operations and dedicates minimal team resources to advancing quality.	Leadership has a vision for high-quality, integrated, equitable care but no detailed strategy for achieving it. Quality improvement is either assigned to a special team or carried out through special projects but is not widely championed throughout the practice.	Leadership has developed and disseminated a vision and strategy for high-quality, integrated, equitable care. Practice sets measurable goals, regularly monitors performance and has dedicated resources across teams to advance quality.	Leadership has developed and disseminated a vision and strategy for high-quality, integrated, equitable care. Practice sets measurable goals and regularly monitors performance. All staff receive quality improvement training and are provided resources and protected time to dedicate to quality improvement goals.		
2	Practice has a defined approach to quality improvement (e.g., Model for Improvement, Lean) that includes a formal process to obtain and incorporate patient feedback.	Practice does not have a standard quality improvement approach and does not have a formal process for obtaining and systematically responding to patient feedback.	Practice has decided on a standard quality improvement methodology. Practice has limited methods for obtaining patient feedback and does not have a system for designing quality improvement activities based on the information received.	Practice has adopted a quality improvement methodology and begun applying it to specific projects or goals. Patient feedback is collected via a variety of methods (e.g., surveys, advisory groups) and is inconsistently incorporated into quality improvement efforts.	Practice staff carry out quality improvement activities using a standard improvement methodology. Patient feedback is collected via a variety of methods and practice documents operational or strategic decisions made in response to this feedback to drive quality improvement efforts.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
Data-Driven Improvement							
3	Practice regularly produces and shares reports on performance at both the organization and provider/care team-level, including progress over time and how performance compares to goals. Practice uses its data to prioritize and inform its quality improvement efforts.	Practice does not regularly produce and/or receive reports on how the practice and/or care teams are performing over time or relative to benchmarks or quality goals.	Practice produces and/or receives some reports on quality performance relative to quality goals but the distribution of the reports is limited or irregular.	Practice regularly distributes reports on quality performance throughout the organization. Data is presented over time and compared to goals and benchmarks. Follow-up on the reports (e.g., using it to inform quality improvement work or decision-making) is inconsistent.	Practice produces timely, accessible, actionable reports on quality performance for care team-level and organization-level users and has an effective system for following up on low performance. Performance data is shared transparently within the practice to inform quality improvement efforts.		
4	Practice has the infrastructure to capture and stratify performance reports by demographic data, such as Sexual Orientation and Gender Identity (SOGI), Race, Ethnicity and Language (REaL) data and other patient-reported data to identify and act upon disparities.	Practice does not have the infrastructure to capture robust demographic data from patients.	Practice has begun to collect important demographic variables, but data capture is poor/incomplete. Practice has started to stratify some reports by available demographic data.	Practice has a robust system for capturing key demographic variables. Practice stratifies by demographic data for most/all patients in the practice and does so regularly when reviewing quality outcomes.	Practice has a robust system for capturing key demographic variables. Practice regularly stratifies quality data by demographic variables and targets interventions and resources to groups with the greatest disparities.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
			Empanelment				
5	Patients select and/or are assigned to specific provider panels and recognize their care team members as partners in care. Panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.	Patients are not assigned to specific provider panels and do not identify with a regular care team.	Multi-provider practice: Practice assigns patients to panels but panel assignments are not routinely confirmed by the patient, used by the practice for scheduling or monitored and adjusted over time. Solo-provider practice: There is no system or routine for regularly reviewing the number of active patients within the practice.	Multi-provider practice: Active patients are assigned to panels and assignment is used to support scheduling and other administrative functions. Practice confirms assignments as patients are scheduled and seen. Practice is not systematically reviewing and updating panel assignments (e.g., balancing supply and demand; removing inactive patients from the panel). Solo-provider practice: Practice has a system for identifying patients as active and utilizes data to support scheduling and other administrative functions. Practice is not systematically reviewing and updating panel (e.g., balancing supply and demand, removing inactive patients from the panel).	Multi-provider practice: Active patients are assigned to panels and assignment is used to support scheduling and other administrative functions. Practice accommodates patient needs and preferences in assignment. Practice updates panel assignments on a regular basis, adjusting panel size based on supply and demand and removing inactive patients from the panel. Solo-provider practice: Practice reviews active patient panel on a regular basis, annually or more frequently and utilizes supply and demand data to inform the decision to keep practice open to new patients.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
				Team-Based			
6	Patients know and receive care from a primary care provider who is supported by members of an interdisciplinary care team. Care team members communicate and coordinate across the team to address patient needs and provide care that is appropriate to their training and expertise.	Care team members, like medical assistants, work with a different provider(s) every day and tend to operate in silos. They play a limited role in providing clinical care.	Care team members, like medical assistants, are linked to a provider(s) but are frequently reassigned. They are primarily tasked with managing patient flow and triage.	Care team members, like medical assistants, consistently work with the same provider(s) almost every day. They provide some clinical services such as assessment or self-management support. Other clinical and support staff are not integrated into the care team.	Care team members, like medical assistants, consistently work with the same provider(s) almost every day and other clinical and support staff are explicitly integrated into the care team. Care team members perform key clinical service roles that match their abilities and credentials (e.g., adoption of standing orders).		
7	Care team workflows and team member roles and responsibilities are well documented to optimize outcomes and efficiency. Care team members are trained appropriately for their roles and responsibilities.	Workflows, roles and responsibilities for care teams are not documented and/or are different for each person or team. The practice does not have an organized approach to identify or meet the training needs for providers and other staff.	Some, but not all, workflows, roles and responsibilities for care teams are documented and standardized. The practice trains care team members to fulfill their roles and responsibilities.	Workflows, roles and responsibilities for care teams are documented and standardized. The practice routinely assesses training needs, ensures staff are trained appropriately for their roles and responsibilities and provides some cross-training to permit staffing flexibility.	Workflows, roles and responsibilities for care teams are documented and standardized; they are evaluated and modified on a regular basis. Practice routinely assesses training needs, ensures staff are trained appropriately for their roles and responsibilities and provides cross-training to ensure that patient needs are consistently met.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
	Person and Family Centered						
8	Practice uses inclusive, culturally-competent approaches to patient, caregiver and family engagement, such as health coaching, motivational interviewing and shared decision-making methods, to help patients manage their health care and chronic illnesses. Patients share preferences and goals of treatment and their choices are respected and integrated into care plans.	Visits largely focus on acute problems and care plans are not routinely developed or recorded. Self-management support, when available, is limited to the distribution of information (e.g., pamphlets, booklets).	Care plans are developed and recorded but mostly reflect provider priorities. Self-management support is accomplished by providing education materials and referral to self-management classes or educators.	Care plans are developed collaboratively with patients, caregivers and families and include self-management and clinical goals. Self-management support is provided by members of the care team trained in patient empowerment and problem-solving methodologies.	Care plans are developed collaboratively, include self-management and clinical management goals, are routinely recorded and guide care at every subsequent point of service. Self-management support is provided by members of the care team and is intentionally designed to be culturally and linguistically concordant with patient needs (e.g., responsive to diverse cultural health beliefs and practices, preferred language, health literacy).		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
	Population Management						
9	Practice uses registry- or panel-level data to identify and act on care gaps across a comprehensive set of preventive services and chronic conditions. Practice identifies disparities in measures related to care gaps and designs culturally and linguistically appropriate supports to reduce those disparities.	Practice does not have reliable access to data on care gaps for its population of patients.	Practice produces or receives care gap reports but the reports are limited to specific payers or diagnostic groups. Practice may contact patients with overdue services as part of special initiatives, but standard care team workflows do not include outreach.	Practice produces or receives care gap reports for a comprehensive set of preventive services and chronic conditions. When patients are overdue for services but do not come in for an appointment, the practice will contact them and request they come in for care. Clinical staff proactively acts on overdue care items (e.g., distributes colorectal cancer screening kits) based on standing orders.	Practice uses robust data on care gaps to conduct patient outreach and close gaps in a systematic way (see scoring criteria 2). In addition, practice stratifies data to identify disparities in population health outcomes related to care gaps and deploys additional supports (e.g., connection to a community health worker, offering transportation) to address disparities.		
10	Practice has a reliable process to effectively identify patients at risk of developing new health conditions, experiencing complications or needing higher-intensity care, including hospitalization. Those at high-risk receive additional support, such as culturally-responsive care management.	Practice does not use data to identify patients at high risk of complications or hospitalization.	Practice uses data to identify high-risk patients, but the approach is not comprehensive or systematic. Practice does not consistently act on risk-level data (e.g., providing care management or care social supports).	Practice systematically uses data to identify high-risk patients and provide care management and other supportive interventions.	Practice consistently identifies and provides culturally-responsive care management and other supports to high-risk patients. The practice routinely evaluates its care management outcomes, including disaggregating performance measures by key demographic variables.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
	Accessible						
11	Practice offers accessible care, including same-day care for urgent needs, minimal wait time for routine appointments and timely after-hours access.	Practice does not measure appointment timeliness or wait time for routine appointments. After-hours access is limited to an answering machine and same-day urgent care is not reliably available.	Practice measures appointment timeliness but access is limited. There are a few same-day appointments for urgent needs, long wait times (>10 business days) for routine care and ad hoc after-hours care.	Practice measures access against timeliness goals and achieves goals intermittently. Practice deploys best practices to ensure same-day appointments and minimize wait time and provides after-hours care by using contract clinicians or a nurse triage service.	Practice achieves appointment timeliness goals consistently and systematically anticipates and addresses access challenges. Same-day appointments are always available. After hours, a clinician with access to the patient's record is available.		
12	Practice uses multiple, technology-enabled methods to offer scheduling and communication options that are convenient for the patient, including alternative visit types (i.e., phone and video appointments), secure messaging, online scheduling and online medical records.	Practice relies on face-to-face encounters and phone interactions with patients. Alternative scheduling and communication options are not offered.	Practice is considering the use of technology to offer alternatives to face-to-face visits and different methods of communication, but has not yet formalized the options or communicated them to patients.	Practice has the capability of providing inclusive alternative visit types or communication options but they are in limited use.	Practice offers multiple forms of alternative visit types (e.g., phone, tele-visits) or communication options (e.g., patient portal, email, texting) and has integrated these alternatives into regular practice.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
Comprehensive and Coordinated Care							
13	Practice has an established universal screening or assessment tool/process that comprehensively identifies patients' specific, addressable and high-impact social needs. Practice has established referral relationships to connect patients with community resources at other organizations.	Practice does not have standardized screening tools to identify patients' social needs or workflows for follow-up. Practice provides patients and families with general guidance about community-based services and resources but does not offer specific recommendations or referrals and does not have contact information for referrals to community-based organizations.	Practice screens patients for one or more unmet social needs in an ad hoc, inconsistent way, which may be required for a specific grant or program. Practice may have staff with dedicated time to refer patients and families to specific community-based services or resources but follow-up is left to the patient. No referral protocol has been set up with community-based organizations.	Practice has adopted a social needs screening tool for the majority of patients. Practice has staff with dedicated time to provide a warm hand-off for referrals to community-based services or resources and may have referral protocols set up but no consistent system is used to track or follow-up on referrals.	Practice routinely utilizes a standardized, universal screening process to identify patients' social needs and refer them to appropriate services. Practice has established and adhered to referral protocols to connect patients with a complete list of community resources and has set up information-sharing processes with these organizations.		
14	Practice has a comprehensive and universal screening or assessment tool/process which identifies all patient behavioral health needs (e.g., depression, anxiety, substance use, tobacco). Behavioral health services are readily available from the primary care team and behavioral health specialists who are either members of the care team or work externally to the practice with a referral protocol in place.	Practice does not have a consistent system for screening and addressing behavioral health needs. Behavioral health services are difficult to obtain reliably via the primary care practice.	Practice has adopted a limited set of behavioral health screening tools (e.g. PHQ-9, SBIRT), however, there is no standardized process to conduct and document screenings. Practice inconsistently refers patients to providers outside the practice. Access is not always assured and no formal relationship is in place between the PCP and the behavioral health provider.	Behavioral health screening (e.g. PHQ-9, SBIRT) is being completed regularly but follow-up is inconsistent. Referrals for treatment are made to behavioral health specialists who are either members of the care team or work externally. A formal referral process is in place but not always.	Practice has a comprehensive and universal screening process which identifies all patient behavioral health needs (including depression, anxiety, substance use, tobacco). When referring patients to behavioral health providers working on- or offsite, practice has established and adhered to referral and information-sharing protocols. Care is timely, convenient and integrated for the patient.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
15	Patients are guided through care transitions across settings, including hospitals, emergency and specialty care. Practice communicates and receives relevant information, follows up promptly and coordinates care with other providers in the community seamlessly.	Patients cannot reliably obtain referrals to other providers or resources in the community. Practice does not regularly receive ADT feeds from hospitals and is not regularly following up with patients after emergency or hospital care.	Patients can obtain referrals to other providers or resources in the community, however, there is minimal follow-up once the referral is made. Practice may receive ADT alerts, but does not have robust systems for following up with patients after discharge.	Patients can obtain referrals to other providers or resources in the community. Referrals are supported through referral relationships between organizations and the practice communicates relevant information to the organization receiving the referral in advance. Practice receives ADT feeds with notifications and strives to follow-up with patients within designated time intervals.	Patients care can obtain referrals to other providers or resources in the community. Referrals are supported through referral relationships between organizations. The practice communicates relevant information in advance and follows-up promptly after the visit occurs. Practice consistently follows up with patients within a designated time interval after ED visits or hospital discharge.		

#	Milestone	0 - Not yet started	1 - Developing	2 - Implementing	3 - Functioning	Score	Notes
			Value-Based Payment				
16	Practice considers itself ready for and is participating in a value-based payment model and has developed the business capabilities to analyze and document the value of various payment models. Financial systems (billing tools, payment systems) and operational workflows are optimized for maximizing payment within value-based arrangements.	Practice payment is primarily fee-for-service-based with no link to quality or value of care. Financial systems and operational workflows are not ready for the migration to value-based care.	Practice payment is primarily fee-for-service with performance-based incentives available, such as bonuses based on quality scores. Practice financial systems and workflows are being developed to support participation in alternative payment models and maximize performance-based payment.	Practice is participating in value-based payment models with only upside risk or will join such a payment arrangement within the next year. A billing system and documentation standards that maximize reimbursement for alternate payment methodologies are being developed.	Practice is actively participating in value-based payment models, which comprise the majority of practice payment. Practice has financial systems, billing tools and documentation standards in place which optimize reimbursement for value-based care. Practice has analyzed the degree to which payment incentives result in revenue exceeding existing rates and its impact on operating cash flows.		