CATEGORIES, ACTIVITIES, AND MILESTONES FOR PROVIDER DIRECTED PAYMENT PROGRAM

Required Categories	Other Categories (Optional)
Practice Transformation Assessment	Evidence-Based Models of Care
Empanelment & Access	Value-Based Care & Alternative Payment Methodologies
Technology & Data	Leadership & Culture
Patient-Centered, Population-Based Care	Behavioral Health
	Social Health

Categories	Activities	Milestones (must be completed in order)
Practice Transformation Assessment	**PmhCAT Completion:** Completion of the PhmCAT each year is required for ongoing participation in the program.	1. PmhCAT submission for year 1 2. PmhCAT submission for year 2 3. PmhCAT submission for year 3 4. PmhCAT submission for year 4 5. PmhCAT submission for year 5
Empanelment & Access	**Empanelment & Access:** Identify a staff member who serves as panel manager, conduct initial patient assignment and supply/demand balancing, and implement ongoing management (panel monitoring, access metrics like third-next available appointments, empanelment, reports and panel adjustments). NOTE: "care team" is used instead of PCP to acknowledge the interprofessional nature of the team caring for a patient	1. Develop empanelment methodology and Key Performance Indicators (KPIs). a. Implement an empanelment methodology (including a formal operating procedure) that supports empanelment. b. Develop empanelment KPIs to support panel management. Include metrics for continuity, access, provider capacity, and mismatches in attribution, e.g. the patient is seeing care team other than their assigned care team. 2. At least one year after completion of the prior milestone, evaluate fidelity to operating procedure by reporting the following based on a single calendar year (CY) of data: a. The percent of attributed patients (both those assigned by MCP and those attributed by practice process) who are assigned to a care team at the practice

		b. The percent of attributed/assigned patient visits with their assigned care team c. Access measures trended over time 3. During a single CY, 90% of attributed patients (both those assigned by MCP and those attributed by practice process) are assigned to a care team at the practice 4. During a single CY, 70% of attributed/assigned patient visits are with their assigned care team
Technology & Data	**Data Governance for Population Health:** Develop and implement a formal structure for population health and quality improvement, including regular meetings of key practice stakeholders who review data and develop/implement strategies to improve population health, healthcare quality, and health equity.	1. Create a data governance workgroup charter which defines goals, structure, participants, and key decision makers. 2. Use data governance workgroup to choose metrics including defining data elements, benchmarks/goals (which should be chosen based on practice's goals and payor expectations), and a method to review and update metrics. 3. Identify specific areas of the organization (e.g. specific teams or individuals) that will monitor these metrics to understand performance and initiate quality improvement efforts. 4. Develop and implement an ongoing evaluation of data governance process and outcomes; specifically, at least one year after prior milestone completion, create a report with the following information: a. Results of all initially chosen metrics b. Any proposed changes to the metric list c. A formal assessment that addresses: ○ Did practice reach metric goals? If no, why not? ○ Does practice need to adjust metric goals/benchmarks and why? ○ Does practice need to add or remove metrics, and why? 5. One year after prior milestone completion, show improvement on at least 3 practice metrics.
	Dashboard & Business Intelligence: Determine the practice's key performance indicators (KPIs, inclusive of HEDIS metrics), collect ongoing data to evaluate KPIs, and present and disseminate KPI reports to stakeholders using business analytics tools (e.g. Excel, Power BI, Tableau, Arcadia, or another similar tool).	1. Develop KPIs including selection of key domains (i.e., utilization, financial performance, quality metrics etc.). Identify appropriate metrics to stratify by race, ethnicity, sexual orientation, gender identify and/or other factors to identify disparities. 2. Assess capabilities of current technology and tools to produce KPIs. Identify any gaps in capability to produce KPIs and build and execute a plan to address (e.g., purchase new tool, upgrade current tool/s etc.). 3. Implement a standard process and structure for distributing KPI report to monitor organizational performance and to gather feedback on opportunities for improvement and successes. Report should be distributed to key internal (and external when appropriate) stakeholders. 4. Demonstrate how KPI metrics are integrated into organizational goals and team (e.g. employee and contractor) performance.

	Data and Quality Reporting Gaps: Determine, create, and implement a formal strategy to address gaps in data that includes a data validation process that identifies gaps and solutions for improving data quality, such as reconciliation with MCPs; data can refer to quality, operational, billing, population health, or other data.	1. Assess and report on organizational KPI data gaps including internal data integrity and external data acquisition (e.g., HEDIS metric, enrollment, claims, encounter, other KPI metrics etc.). 2. Create a workplan to address each data gap identified with specific goals and timeframes. Identify barriers to addressing data gaps that organization is unable to solve for. 3. Create formal report on progress to close data gaps at least one year after prior milestone. Set specific goals for improving data gaps over one year. 4. At least one year after the prior milestone is completed, show progress towards goals in closing specific data gaps.
	New/Upgraded Electronic Health Record (EHR), and/or Population Health Management (PHM) Tool: Ensure the practice has the EHR and/or population health management tools need to maximize clinical, operational, financial, and population health needs. This activity is considered already met if the practice has all the tools they deem necessary.	1. Conduct formal written analysis of the gaps in functionality of the current EHR and/or PHM tools. 2. Solicit formal bids for new EHR/PHM tool or upgrade to existing EHR/PHM tool to address the gaps in functionality. 3. Implement new/upgraded software/tool. 4. At least one year after prior milestone, show how the new software/tool addressed gaps in PHM functionality.
	Data Exchange: Establish, maintain, and use bilateral data feeds with a Data Exchange Framework (DxF) Qualifying Health Information Organization (QHIO), as defined by the current DxF framework and to be further defined in future DxF policies.	1. Formalize the costs of implementation of DxF-QHIO (must include bidirectional data transmission); for example, practice might obtain a formal bid from a DxF-QHIO vendor. 2. Execute contract for a DxF-QHIO. 3. Demonstrate bi-directional data exchange through the contracted DxF-QHIO. 4. At least one year after prior milestone, show at least two use cases of DxF-QHIO data being used to improve individual patient care and other PHM activities.
Patient-Centered, Population-Based Care	**Care Team Design and Staffing** Define and implement a care team that addresses population health management functions (e.g., gaps in care closure, care coordination) and team-based care for the population of focus.	1. Formally determine core care team model incorporating population health management functions and roles. 2. Conduct assessment of current core care team to identify gaps in functions and roles. 3. Create a plan to implement new core care team model to address gaps including those identified for population health management function and roles. 4. Implement plan for new core care team model with existing team members (if not possible, see milestone 6). 5. Evaluate impact of core care team design on KPIs or other metrics relevant to the care team model implemented. 6. Build strategy to source (i.e., hire new staff, redeploy existing staff, retraining existing staff etc.) new care team roles with consideration of financial and other impacts. 7. Implement strategy to source new care team roles (i.e., post positions and hire new staff, initiate retraining etc.).

		8. Evaluate effectiveness of hiring and retention efforts to sustain new care team model by showing improvement in KPIs/metrics in #5 above.
	Stratification to Identify Disparities: Use data to stratify services and/or outcomes measures by variables that might demonstrate health disparities (e.g. race/ethnicity, sexual orientation/gender identity, etc.), and implement a strategy to decreases any disparities identified.	1. Stratify population of focus metrics and/or KPIs by demographic variables (race, ethnicity, sexual orientation, gender identity etc.). 2. Create a formal plan to address identified disparities. This should include a root cause analysis, patient, provider, and community feedback, and process to monitor and adjust plan as needed. 3. Implement the disparities reduction plan. 4. At least one year after prior milestone, show improvement in population of focus metrics and evaluate implementation of the disparities reduction plan.
	Clinical Guidelines: Choose and implement evidence-based clinical guidelines.	1. Select evidenced-based clinical guidelines that can improve the care for the chosen population of focus. 2. Implement clinical guidelines including communication of guidelines to staff, adapting workflows based on clinical guidelines for patients seen in clinic and patients not seen in clinic, and integration of workflows into the practice's EHR (where possible). 3. At least one year after the prior milestone, implement an approach to monitor adherence to clinical guidelines which includes examining clinical metrics and report results to stakeholders (which would include, at minimum, practice staff and leadership). 4. At least one year after #3 above, show improvement in at least 2 clinical metrics tied to the implementation of clinical guidelines.
	Implement Condition-Specific Registries: Create, implement, and use condition-specific registries.	1. Build and implement technology plan to create and utilize a registry. May require purchase of tool. 2. Develop processes/workflows to use and identify which staff will use and maintain the registry. 3. Implement registry. 4. At least one year after the prior milestone, complete formal written evaluation of registry use including process measures and impacts on population of focus measures (e.g. but not limited to: HEDIS, utilization, and/or satisfaction metrics). 5. At least one year after #4, show improvement in at least 2 population of focus measures tied to the implementation of condition-specific registries.
	Proactive Patient Outreach and Engagement: Create and implement a formal strategy to better engage and outreach to patients, including patients assigned but not seen.	1. Perform an analysis of the current state of patient outreach to the selected population of focus. This should include the assigned but unseen population as well as a review of outreach activities (ideally stratified by key demographics, e.g. race, ethnicity, sexual orientation, gender identify, etc.).

		2. Develop a patient engagement strategy that includes patient feedback, experience, and preferences and incorporates attention to identified disparities. 3. Implement patient engagement strategy. 4. At least one year after the prior milestone, evaluate engagement strategy including effectiveness of the approach to engaging the assigned but unseen as well as engaging those populations with identified disparities. This evaluation must report the annual percent of patients assigned but not seen, overall and at least one subpopulation with identified disparities. 5. At least one year after the prior milestone, show improvement in report the annual percent of patients assigned but not seen, overall and at least one subpopulation with identified disparities.
	Pre-visit Planning and Care Gap Reduction: Create and implement a formal process for pre-visit planning (that at minimum addresses gaps in care).	1. Conduct analysis of current pre-visit planning process and develop an approach that includes the following elements: use of standing orders, huddles, transitions of care data (which might include admission, discharge, and transfer (ADT) feeds), and method to identify open care gaps. 2. Implement, refine, and revise pre-visit planning process to optimize effectiveness. 3. One year after completion of the prior milestone, evaluate pre-visit planning approach including impact on care gap closure (e.g. HEDIS metrics). 4. At least one year after completion of the prior milestone, show improvement in at least 2 HEDIS metrics showing care gap closure.
	Care Coordination: Create and implement a formal strategy to address care coordination needs for patients with more complex health and health-related social needs.	1. Determine strategy to identify patients with care coordination needs, which must be a formal risk stratification method (that can be described and implemented consistently). The method can include any type of data that is relevant (including but not limited to diagnoses, utilization, staff report, etc.). Strategy should explicitly address transitions in care from one level of care to another (e.g. hospital discharge). 2. Apply risk stratification methodology to, at a minimum, selected population of focus. 3. Develop and implement care coordination services. Will include identifying services needed (whether internal or external), identifying/hiring any needed staffing resources, training, and any needed technology. 4. One year after the prior milestones, evaluate impact of care coordination strategy including impact on practices KPIs (especially the population of focus). 5. At least one year after the prior milestone, show improvement in at least 2 of the above KPIs in the population of focus.

Evidence-Based Models of Care	**New/Expanded Care Delivery Model:** Choose and implement an evidenced-based model for focus population (e.g. Dyadic Care, Centering pregnancy, group visits for conditions like diabetes, Project Dulce, collaborative care model for behavioral health, Medication Assisted Treatment, etc.).	1. Develop evidenced-based model, from a list of options provided by DHCS, that is co-designed by feedback from patients, providers, and care teams evidenced by policies/procedures (or equivalent) and key findings from co-design. 2. Develop business case and/or sustainability model for new care delivery model; understand impact on practice revenue and cost. 3. Define and report baseline data on key measures. Should include and not be limited to Bold Goals and MCAS measures. 4. Implement care delivery model. 5. Scale model to deliver service to 70% of patients within the population of focus; delivery of services means a documented and discrete reportable service delivered to the patient (whether billable or not). 6. At least one year after the prior milestone, show improvement in at least 2 Bold Goals and/or MCAS measures.
Value-Based Care & Alternative Payment Methodologies	**FQHC APM**: For FQHCs only, complete readiness activities for the APM, apply for the FQHC APM, prepare for APM implementation, and implement the APM (FQHCs who have applied for and been accepted CAN still choose this activity).	1. Conduct Assessment of APM readiness (including PHMI business case tool, PhmCAT, any available DHCS readiness checklists, and additional deep dives into financial, data, operational, clinical gaps as needed). 2. Formally identify gaps and action plan with technical assistance from experts (internal or external) in collaboration with MCP(s). 3. Completion of action plan with re-assessment of APM readiness demonstrating no critical gaps in collaboration with MCP(s). 4. Application submitted for FQHC APM (if not already completed). 5. Entry into FQHC APM once accepted.
	Value-Based Payment: Complete readiness activities and then begin a value-based contract with at least one Medi-Cal MCP (consistent with HCP-LAN category 3 or 4).	1. Conduct assessment of value-based payment readiness (PhmCAT and additional financial, data, operational, clinical domains). 2. Formally identify gaps and action plan with technical assistance from experts (internal or external) and discuss results with MCP(s). 3. Establish value-based contracting model with one or more Medi-Cal MCPs (may range from quality adjusted primary care capitation to total cost of care upside only or up and downside risk, joining ACO or CIN model for a specific population of patients, or other HCP-LAN category 3 or 4 contracting arrangement). 4. Address identified gaps in value-based payment readiness assessment, develop necessary infrastructure to succeed in value based contracting arrangement with Medi-Cal MCP(s); create plan to address gaps. 5. Pass MCP readiness review and/or pre-delegation audit for value-based contract. 6. Initiate value-based contract for 12-month period or longer. 7. Evaluate performance in value-based contract with MCP and assess future contract terms.

Leadership and Culture	**DEIB Strategy:** Create and implement an organizational-wide strategy to work on diversity, equity, inclusion, and belonging (DEIB).	1. Develop a DEIB framework, approach, and goals for practice, with support from experts (including those at other similar organizations) and input from practice staff, patients and community. 2. Develop and document a formal DEIB plan (including how it relates to any existing overall strategic plan for the organization) and define quantitative/qualitative measures of success and achieving goals. This plan should address health equity for patients of the practice. 3. Implement formal DEIB plan and monitor adoption, barriers and adjustments to be made. 4. At least one year after prior milestone, evaluate DEIB plan on, incorporating feedback from stakeholders including practice staff, patients and community members as well as reporting on results of quantitative and qualitative measures, including qualitative measures related to improving health equity for patients of the practice. 5. At least one year after prior milestone, show improvement in at least 2 measures of health equity for patients of the practice.
	Strategic Planning: Create and implement a formal process to address the practice's strategic planning (which must, at minimum, address DEI and patient and community partnership/engagement, patient access, quality metrics, health equity, workforce satisfaction and retention, and value-based care).	1. Define key elements of strategic plan (which should be for a minimum of three years), including but not limited to the following: mission/vision/values, landscape assessment, internal analysis (e.g. SWOT), strategic direction to reach vision for future state, clear goals, objectives, and metrics (must cover at minimum DEI/health equity, patient and community partnership/engagement, patient access, quality, workforce satisfaction and retention, and value-based care), activities that the practice will undertake to reach goals and objectives over the period of the strategic plan 2. Incorporate and document clear process for obtaining stakeholder feedback on strategic plan – including frontline staff, management, patients, and community members. 3. Write and publish strategic plan, including communication of plan with all stakeholders. 4. At least one year after prior milestones, show improvement in at least 2 metrics and assess progress toward goals and objectives through written report to stakeholders.
	Patient and Community Partnership/Engagement: Choose and implement a strategy to ensure patient and community input on practice governance and decision making (e.g., a patient advisory committee, seeking to increase patient representation on the organization's board, etc.).	1. Develop and document a strategy for patient and community engagement that is informed by patients and community members, evidence-based and best practices, and priorities set by the patients served by the practice. Obtain direct feedback on the strategy from patient and community members as well as practice staff. 2. Define and document specific actions to be taken to enhance patient and community engagement, including SMARTIE goals and

		activities that will be implemented to achieve goals. Patients and community members should be compensated for their time. 3. Implement patient and community engagement activities. 4. At least one year after prior milestone, show improvement on at least 2 metrics related to goals and objectives, including feedback from patients, community members, and practice staff.
Behavioral Health	**Behavioral Health Integration (BHI) in Primary Care** Integrate behavioral health into primary care practice to provide more comprehensive care for patients.	*NOTE: Medication Assisted Treatment (MAT) may be the model of care chosen in "New/Expanded Care Delivery Model", which is an optional activity. Primary care-based MAT does not necessarily require full behavioral health integration (as medications are prescribed through primary care); however, a practice may decide to implement integrated behavioral to strengthen its MAT program.* 1. Define behavioral health (BH) screening (which might include traditional BH screening like PHQ-2/9 or AUDIT-C, and/or other related screenings like ACE and intimate partner violence screening) approach for the practice, including: specific tools/questions to be used for screening, patient populations that will be screened, frequency of screening, screening data capture and reporting mechanism, protocol for triage of patients based on screening results and linkage to appropriate level of behavioral health services (e.g. provider, peer counselor, group, specialty mental health, crisis intervention services, etc.). 2. Define baseline key operational and quality metrics to monitor progress and determine effectiveness of BH screening; develop a reporting system for these metrics. 3. Develop and document required operational workflows and EHR/HIT system modifications to support behavioral health screening. 4. Implement behavioral health screening strategy. 5. Select evidence-based model for integrating behavioral health services into primary care, such as the Collaborative Care Model, Behavioral Health Consultant Model, or other approaches integrating key evidence-based activities for BHI that include: a. How integrated BH is linked to screening in milestone #1. b. Team-based care with staff to support primary care physicians (PCPs) and co-manage treatment. c. Shared information systems (e.g. EHR or other platform) that facilitate coordination and communication across providers. d. Standardized use of evidence-based clinical guidelines. e. Systematic review and measurement of patient outcomes using registries and patient tracking tools. f. Engagement with broader community services.

		g. Individualized, person-centered care that incorporates family members and caregivers into the treatment plan. 6. Create a baseline report on operational and quality metrics to monitor progress and impact of BHI model. 7. Implement evidence-based model for behavioral health integration. 8. At least one year after implementation, show improvement on at least two quality metrics related to BH screening and formally evaluate the impact of BHI model on key operational and quality metrics.
Social Health	**Social Needs/Risk Screening and Intervention:** Create and implement a formal process for screening for and intervening on patients' social needs/risks	1. Develop a health-related social needs screening and intervention strategy that includes documented activities, workflows and procedures that support the key elements of social health integration into primary care as outlined in the National Academy of Sciences. If the practice already does social needs screening and intervention, then adopt a plan to meet criteria above. 2. Set specific goals, objectives, and timeframes for each element of the 5 As (adjustment, assistance, alignment, advocacy, and awareness) outlined as in the National Academy of Sciences framework. 3. Exchange social health data with local CIE/HIO and Managed care plans. 4. At least one year after implementation, complete written evaluation of implementation of social needs screening and intervention strategy, including number of patients screened and linked to services annually, progress toward practice specific goals and objectives, and key barriers and learnings during the implementation process.