Final State Innovation Model (SIM) Contractor Report to Colorado Department of Health Care Policy and Financing

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Abstract

Accomplishments:

Over the past year, the Colorado Community Health Alliance (CCHA) has been working closely with Foothills Behavioral Health Partners (FBHP), the community mental health centers and the Primary Care Medical Providers (PCMPs) to improve the quality of care provided to Medicaid members shared by CCHA and FBHP and to reduce the overall cost of care. CCHA has used the $30,000 contract from the Department of Health Care Policy and Finance (Department) as part of the State Innovation Model (SIM) to advance some of the initiatives already underway and to explore new opportunities for co-locating behavioral health providers and supporting providers in integrating behavioral and physical health care services. Specifically during the nearly three months of the contract CCHA has:

- Made refinements to the Health Care Management pilot (HCM) for a collaborative approach to providing care coordination for individuals with behavioral health diagnoses;
- Continued to explore data sharing opportunities and problem-solve issues in obtaining from FHBP a roster/list of ACC Program members that have had a behavioral health encounter. In January, prior to this SIM work, CCHA provided the initial list of ACC Program members for the purpose of stratifying members and developing interventions that are clinically appropriate and will enhance care coordination. Over the past several months CCHA and FHP have been negotiating on the scope and services to be provided to members and CCHA has been reviewing reports provided by FBHP. An example is attached as Appendix I;
- Identified four PCMP practices in Jefferson County for potential co-location of a behavioral health provider. CCHA and FBHP continue to work with practices in Jefferson County as well as in Boulder and Broomfield Counties to identify other sites and to support sites that are already co-locating or are integrated further. Data analysis of behavioral health needs of Medicaid members will be used to identify additional sites and to support providers;
- Spoken with four practices (two that have a co-located behavioral health specialist and two that were identified) to learn about concerns, challenges, successes and best practices; and
- Increased the number of ACC Program members attributed to PCMP sites that already have a co-located behavioral health provider including all area located FQHCs.

Outcomes:

During the past several months:

- CCHA has identified four sites for co-location. One site has a tentative start-date of early November;
- There are more ACC Program members attributed to PCMPs that have a co-located practitioner;

- CCHA and FBHP continue to work through the details required to implement the HCM Care Management Pilot; and
- CCH has held several meetings and conversations with partners to identify future sites and support transition to more complete integration.

Substantive Findings:

During the discussions with the practices, CCHA came to realize the importance of working with practices *where they are* in terms of practice transformation, approach to new initiatives and willingness to change their practices. Prior to the discussion, CCHA was well aware of the oft-identified challenges of finding space, reimbursement and potential scheduling and time burden on the PCMPs. During the discussions, it became clear that practices that have a culture of practice transformation and have gone through some sort of accreditation process will be more likely to embrace integration and more able to make the practice changes. This does not mean that CCHA will not pursue other practices but in doing so will need to provide opportunities for additional practice coaching and, perhaps, mentoring from practices further along the spectrum of integration.

Additional findings include: the importance of relationships between providers, the ongoing challenges with sharing data and care plans due to limitations imposed by the Health Insurance Portability and Accountability Act (HIPAA) as well as 42 CFR Part 2; and challenges with coordinating care and collaborating when it is not a reimbursable activity.

Suggestions/Recommendations:

As next steps, CCHA recommends that the Department permit CMHCs to be PCMPs. Also, all entities should continue to explore how to make data and information timely and readily available by, for example, providing direct access to the SDAC warehouse for FBHP and behavioral health providers. Finally, in developing the Model Test Grant Proposal to be submitted to CMS, CCHA recommends that the State solicit input about the proposal and continue to work with partners, including the behavioral health organizations, the Regional Care Collaborative Organizations (RCCOs) and the providers to ensure the proposed model provides improved care coordination and better serves CCHA and FBHP enrollees..

Additional Information:

None at this time.

I. Introduction

CCHA is the Regional Care Collaborative Organization (RCCO) for Region 6 which encompasses Boulder, Broomfield, Clear Creek, Gilpin and Jefferson counties. CCHA is a collaboration that was formed in 2010 between Centura Health, Physician Health Partners, and Primary Physician Partners to focus their combined expertise and efforts on improving the quality, efficiency and delivery of health care for Coloradans. As the designated RCCO for Colorado Medicaid Region 6, CCHA's role is to help guide care and improve outcomes for Medicaid members. Region 6 is unique in that the region overlaps exactly with Medicaid's regions for their Behavioral Health Organization (BHO). As a result, the BHO partner, Foothills Behavioral Health Partners (FBHP), and CCHA have established a very strong relationship with an intense focus on the residents of the counties in which they serve, in particular Accountable Care Collaborative (ACC) Program enrollees.

CCHA received a $30,000 grant from the Department of Health Care Policy and Financing (Department) as part of the state's State Innovation Model (SIM) grant from the Centers for Medicare and Medicaid Services. The grant was to support CCHA in planning for and taking steps to integrate further physical and behavioral health care for clients enrolled in the ACC Program. CCHA contracted with Health Management Associates (HMA) to support them in completing the following tasks:

- Documenting and finalizing the processes that have allowed CCHA and FBHP to integrate and aggregate behavioral and physical claims data;
- Identifying CCHA contracted Primary Care Medical Providers (PCMPs) for co-location with a Jefferson Center for Mental Health (JCMH) or Mental Health Partners (MHP) employed behavioral health provider by January 1, 2014;
- Creating a final report to include activities attempted and completed, the process for communicating and exchanging data and care management plans, and an assessment of current Statewide Data Analytics Contractor (SDAC) data capabilities and limitations.

This final SIM Contractor report is written from the perspective of CCHA and is, therefore, primarily focused on the Medicaid population, in particular the Medicaid population enrolled in the ACC Program.

II. What is the "as is" state of health in Colorado from CCHA's perspective?

CCHA and FBHP have developed strong relationships and are committed to providing coordinated and collaborative care to the ACC Program enrollees in Region 6. Despite the strengthened relationship, renewed focus on ensuring ACC Program members receive the right care in the right place at the right time, and a focus on integrating behavioral health and physical health care, the system does not always "make Coloradans healthy." There is a lack of data and information sharing across care, insufficient data for population management activities and payment mechanisms do not support collaboration, integration and value-based purchasing. This is particularly true for those with high behavioral and physical health needs.

All Medicaid individuals receive behavioral health care under one delivery system and payment structure and physical health care under another. Individuals with high needs and multiple chronic conditions often have multiple care coordinators, providers and support systems. These care coordinators and providers are unable to share data and information and are not reimbursed for the time-consuming but important collaboration that must take place for individuals' health to be improved. Certainly, a change in delivery system and payment structure does not *guarantee* that care will be coordinated, that information will be shared and that enrollees will move from having multiple care coordinators to having a primary point of contact. Nor does the system today mean that care can't be coordinated or information shared, though the current structure can make this more challenging. To address these systemic problems in advance of a SIM model test grant, re-procurement of the BHOs, re-procurement of the RCCOs, and a shift to the RCCOs assuming greater risk for all care, which will enhance the integration of behavioral and physical health care, CCHA and FBHP are partnering on many initiatives, which are described in detail below.

III. What is the preferred "to be" state from CCHA's perspective?

From CCHA's perspective, in the preferred "to be" state, behavioral health and physical health services are provided to clients in a seamless way, and in bi-directional integrated settings. These bi-directional integrated settings are anticipated to exist at behavioral health sites, federally qualified health centers (FHQCs), and other primary care practice sites. Clients will choose the setting they want to receive care in based on their health status and needs. Each team at the PCMP site will have access to information that gives them a complete picture of the member's full health status and needs. Through care coordination vested at the site, providers are able to provide appropriate services and make appropriate referrals. Teams at PCMP sites understand and operate from the perspective that they are part of a care team, and the care of the client is facilitated by the sharing of relevant information (according to federal law) through shared care plan, and regular in-person meetings between providers. PCMP site leadership supports integration, and integration is supported by payment methods that are integrated and that support coordination of care and communication between providers.

What this means in practical terms can be described by looking at how data are shared and utilized, and how services are delivered. In terms of data exchange and data sharing, CCHA envisions and is working toward a system in which data are shared between the BHO, the RCCO, the PCMPs, and the behavioral health providers, and are used to improve care and health outcomes. Ideally, these data would be real-time and available during patient visits.

In terms of how services are delivered, CCHA envisions and is working toward a system in which patients are able to seek behavioral health services in the setting in which they are most comfortable, and population-based physical and behavioral health screenings are universally administered in these settings. Primary care providers are aware of, and have immediate access to, behavioral health resources and are able to make referrals and warm handoffs, and care plans and clinical notes are developed collaboratively and shared. Behavioral health

providers are aware of the linkages between patients' behavioral health needs and their physical health needs, and are able to support integration by making referrals to physical health providers and by providing behavioral health services that increase patient engagement in their own health and patient management of chronic conditions.

IV. What is the "innovation opportunity" (i.e. the gap between "as is" and "to be") for CCHA?

The gap between the "as is" and "to be" states described above means that, currently, patients receive fragmented care, providers are unaware of resources they can rely on, billing is complicated and cumbersome, and health record systems are not conducive to integration. These problems have been well-documented in study after study, and both clients and providers are well aware of, and live with, these challenges every day.

This gap between the "as is" and "to be" states provides multiple opportunities for innovation. CCHA and its behavioral health partner FBHP have begun activities and initiatives in response to these opportunities already, and are planning additional activities and initiatives. To move toward the "to be" state, CCHA has begun work with its behavioral health partner (FBHP), and with primary care and behavioral health providers on a variety of fronts. These are described in greater detail below, and are as follows:

- Data Sharing and Data Exchange
    - Ongoing discussions on potential development of and uses for a comprehensive data set; as well as exploration of approach to implementing shared care plans
    - Supporting better use of data to identify opportunities for enhanced interventions and/or care coordination.
- Co-Location and Service Integration Activities
    - Supporting movement toward co-location for practices that do not have co-location;
    - Supporting more ways to utilize behavioral health providers if the practice is already co-locating;
    - Supporting higher levels of integration among all practices, regardless of their current status;
    - Supporting providers in developing sustainable billing strategies, including strategies that are feasible under current billing regulations and guidelines, and supporting providers in building capacity to move toward being able to manage billing under different structures, including global payment, more shared risk and shared savings;
    - Working with payers to change payment methodology away from basic fee for service toward value-based payment that allows for shared risk and shared savings at both the ACO and provider level; and
    - Supporting shared learning across practices, such as space issues, scheduling and work flow issues, billing, tracking savings, measuring health outcomes and patient satisfaction.

A. Innovations Related to Data Sharing and Data Exchange

There are many aspects of data sharing that are critical to integration of physical and behavioral health. These include primary care providers and behavioral health providers:

1. Having access to a full set of claims data that includes both physical and behavioral health claims to the extent allowable by federal law;
2. Knowing how to use the data to identify opportunities for improved care coordination and needed interventions; and
3. Creating, having access to, and using shared care plans and clinical information for patients that take into account both their behavioral and physical health care needs (and how these intersect and interact with each other, including medication management).

Historically, the kind of shared data described above has been almost nonexistent, or limited to small pilots, and these are significant barriers to integration. In the "as is" state for the counties served by CCHA and FBHP, very little data sharing across behavioral health and physical health has occurred. However, since early 2013, this has begun to change via initiatives undertaken by CCHA and FBHP. Initiatives already underway, and those that are in the planning stages, are described below.

1. Current Initiatives

a. HCM Care Management Pilot

This pilot initiative utilizes shared data, is already underway and will establish a best practice that will improve care coordination and care management for members with severe mental illness (SMI), specifically those with schizophrenia, schizoaffective, or bipolar disorder. This pilot was developed to address gaps identified in an earlier focus study (completed in State Fiscal Year 2012) called the "Design of a Healthcare Management Program." The gaps identified were documentation of basic screening, health risk assessment, care coordination and health education for the SMI population. In particular, findings indicated a significant gap in documentation of physical health risk factors and related care coordination. This study highlighted the importance of implementing and supporting a best practice care coordination/care management guideline for this at risk study population. Because it is a pilot, the initiative will start small and, once more is known about how to implement, the parameters of what works and what the challenges are, the model could be expanded.

CCHA (with FBHP) is undertaking several strategies to provide better care to the SMI population, including collaborative efforts to increase the percent of the at-risk study population that is enrolled to the RCCO (FBHP analysis found that only 11 percent of the at risk study population are enrolled to the RCCO). Together, FBHP and CCHA are working towards improved access to physical health and utilization information and increased access to care coordination for at risk clients.

Additional strategies are implementation of a healthcare management program, use of an enhanced EHR (detailed Registry) to monitor risk and prompt follow up care, other enhanced care processes, and the establishment of procedures to increase enrollment of the study population, increase care coordination provided to them, and develop process to increase routine health information exchange and tracking. Since the beginning of the project, the number of clients enrolled in CCHA has increased, as has the number of clients with an identified PCMP. For those clients who have enrolled, their physical health claims data has been utilized to increase tracking of "high risk" clients, and focused efforts have been made to obtain releases for care coordination, and increase outreach and engagement with members and their PCMPs.

Using claims data from January 2013, it is estimated that there are some 3,600 CCHA enrolled members with "high behavioral health care costs." The intention of this initiative is to explore the best way to develop and implement a collaborative approach to providing care coordination between CCHA and FBHP. The initial focus will be on coordinating care for those members who are highly unstable and have high physical and behavioral health care needs.). The specific interventions have not been determined, though they may include approaches such as assigning a CCHA Health Partner with whom FBHP care coordinators can work. CCHA currently assigns a Health Partner to each PCMP practice. The Health Partner has the primary responsibility for PCMP and member/family contact, assistance with care coordination, and communication. Because the Health Partner is assigned to the PCMP while the FBHP care coordinator would be assigned to the client, CCHA and FBHP will explore activities such as holding monthly care coordination meetings with the CCHA and FBHP care coordinators and Health Partners to ensure exchange of information and care plans. CCHA and FBHP are planning to target specific PCMP sites with high concentrations of these members to test interventions and evaluate an approach that could work for additional members.

Another potential intervention under discussion between FBHP and CCHA would be for CCHA to delegate care coordination responsibility to FBHP for clients with specific behavioral needs. The community mental health centers through the BHO would provide all the care coordination for the members attributed to the PCMP pilot sites. The ultimate goals would be to ensure that care coordination is provided by a single behavioral health provider of the member's choice and that RCCO, PCMP and BHO contract requirements are met.

To measure success, CCHA will use the following indicators:

1. Percent of study population with >=80 percent of items receiving a "met" status on key components of the Healthcare Management Program (medical record audit using Healthcare Management Audit Tool);
2. Percent of study population enrolled in the RCCO and with attributed PCMP (physical health claims data and information exchange FBHP/CCHA); and
3. Health outcomes (chronic physical health issues, physical health "at risk" factors, and healthcare utilization data) for the study population.

Ongoing challenges associated with this initiative include privacy requirements regarding the sharing of substance abuse data and inability of care coordination software to facilitate shared care plans and care coordination activities. CCHA's current system cannot accommodate this because the system includes more than Medicaid lines of business and there is no way to "filter'" people. CCHA is issuing a Request for Proposals (RFP) to obtain new care coordination software, and plans for this software to provide a solution to this problem by the beginning of 2014.

As findings begin to emerge from this pilot, CCHA and FBHP will explore possibilities for expanding it to more people with behavioral health conditions and possibly to other populations. CCHA views this pilot as a potential and promising stepping stone toward using behavioral health providers to deliver more of the care coordination functions for people with behavioral conditions as is anticipated when the BHOs and mental health centers are designated PCMPs members with high behavioral needs.

b. Population Management Project

Beginning in January 2013, CCHA began to work with FBHP to exchange client-level physical health claims data and create a comprehensive data set for patients enrolled by CCHA who had behavioral health services paid for by FBHP in the past three years. The steps that were taken to allow for and facilitate the data exchange, the purposes of the data exchange, and the challenges that were faced throughout the process are provided below. This is followed by details regarding the outcomes of the data sharing. Last, an overview of next steps and plans for additional data sharing and additional utilization of the shared data are provided.

Steps to Create Exchange

Before beginning the exchange of data, steps were taken to ensure that data could be legally shared and that there was a need for data sharing. First, both FBHP and CCHA ensured that they are "HIPAA Business Associates (BA)" of Colorado's Department of Health Care Policy and Financing (HCPF). In order to meet their contractual obligations to HCPF, both FBHP and CCHA need client-level data in order to:

1. Better coordinate care (a requirement of both entities);
2. Complete the HCM Care Management Pilot project (a focused study for HCPF); and
3. Develop population management solutions.

Both organizations' data needs fell into two HIPAA categories: "health care operations" and "contracted services/business associate activities". Coordination of care and health care management projects are both "health care operations" (HCO). Entities may share data for HCO if both entities have, or had, a relationship with the member. HCPF's definition of "relationship" for a BHO means paying for services within past 12 months. For the RCCO (which, in this case, is CCHA) it means the member has been enrolled in that RCCO in the prior 12 months. There is no BA agreement required for this type of transaction.

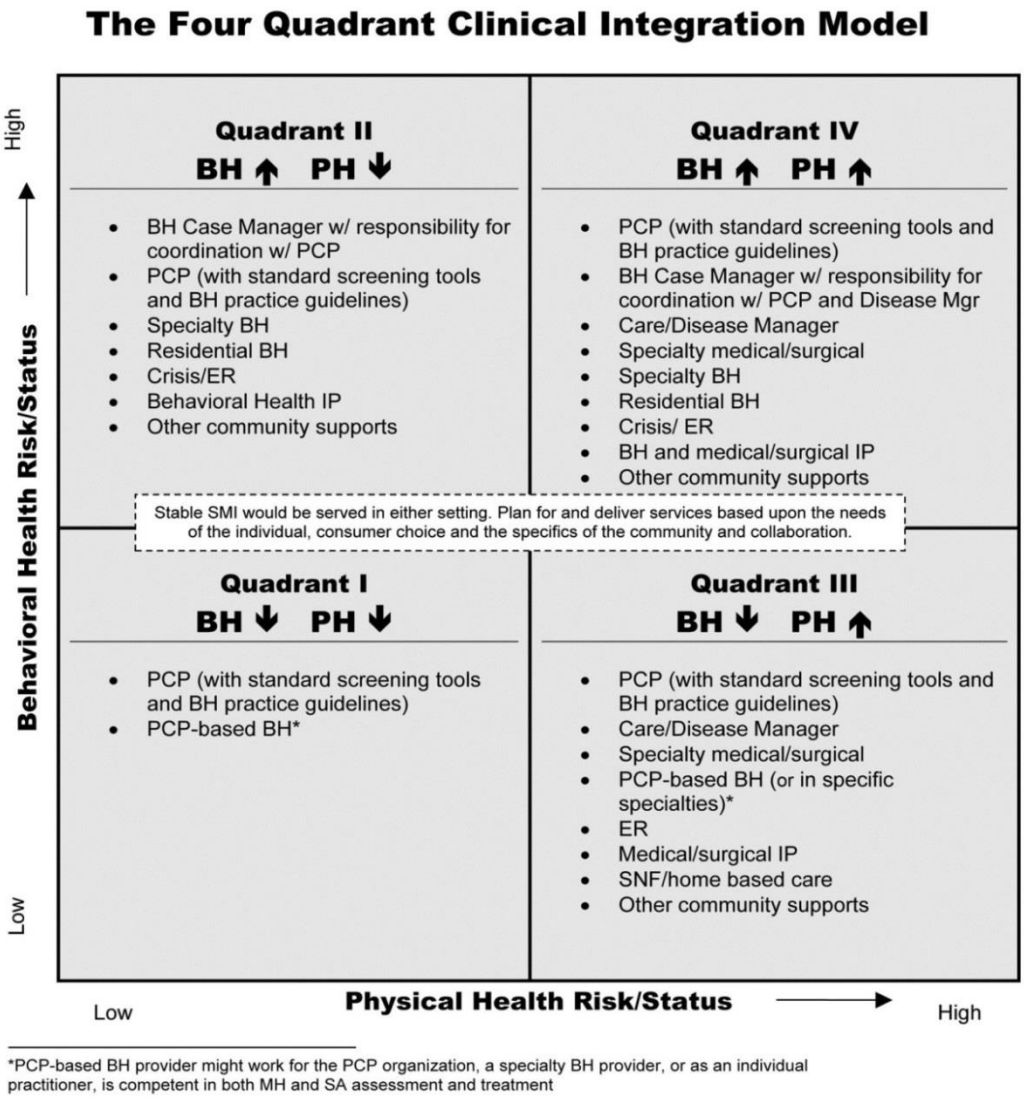
The population management project involves FBHP evaluating data on behalf of CCHA to identify clients that are using behavioral health services and recommend solutions to improving the care provided to CCHA ACC Program enrollees. In this instance, FBHP is acting as a business associate of CCHA and therefore signed a HIPAA BAA. Data does not belong to FBHP and can only be used to support CCHA operations (that are HIPAA compliant). For this project, CCHA has provided to FBHP a roster/list of ACC Program enrollees in the RCCO. FBHP used this list/roster to identify ACCO Program clients that have had a behavioral health encounter (claims and chart information are not provided) and include this information on the roster/list which will be sent back to CCHA. Claims and chart information will not be provided.

Purposes of the Data Exchange

The analysis has allowed both the development of new identification tools and algorithms to identify members with specific care coordination needs and helped reduce fragmentation of planning for service needs. Goals of this information transfer are to:

- Identify CCHA patients with behavioral health needs using available data (BHO paid services, pharmacy claims data, secondary behavioral diagnoses, or a behavioral health code reimbursed outside of a BHO)
- Stratify members using the four-quadrant model (National Council for Community Behavioral Health 2006).
- Work within the data sharing requirements and respect patients' rights to have their privacy protected while still getting information to providers to improve care for their patients.

Upon receipt of the roster/list, the intention is for FBHP to use the shared data to stratify members into the four-quadrant model (from the National Council for Community Behavioral Healthcare, 2006 and depicted below) for the purposes of supporting CCHA operations. This information and stratification will help CCHA support PCMPs in providing clinically appropriate and legally compliant interventions as well as additional care coordination to better meet the needs of members. FBHP and CCHA will explore how to develop interventions that are based on best practices from other states and the experience and expertise of FBHP providers and PCMPs. Also, interventions will be developed that consider the local context and structure of the current delivery and payment systems.



Challenges Associated with Sharing Data

Initially, there were a number of challenges to overcome in the process of sharing data. First, the behavioral health data that were exported from the state's "Statewide Data and Analytics Contract" (SDAC) data warehouse were incomplete and had some inaccuracies. Once FBHP received the exported data, the behavioral health data was removed and replaced with more accurate data drawn from FBHP's systems. This allowed for a more complete picture of the services received by clients. However, the file still is not complete because FBHP cannot include substance use data because the disclosure of those data is limited by federal regulations (42 CFR Part 2). This is a tremendous legal barrier; CCHA and FBHP do not believe these restrictions will be changed in the near future. Another limitation of the data file is that the data is not "real time". Therefore, data is always months out of date.

Despite these limitations, the data provides a useful picture of the physical and behavioral health services and needs of members. Once members are stratified into one of the four quadrants, appropriate care coordination activities are tailored and provided to that member. FBHP is in the process of breaking the data down to the provider ID level, to be used by the primary care provider and the behavioral health clinician to provider those tailored services and interventions, and additional care coordination and linkage to additional community resources and other resources if needed.

c. Adult Quality Grant Depression Screening

Another initiative currently underway that utilizes data sharing and exchange is the development and implementation of a standardized depression screening tool and referral process for use among all PCMPs. This standardized referral processes will strengthen collaboration between PCMPs and the community mental health centers and will mitigate challenges related to access to services once depression is identified. To date, CCHA has successfully completed workflow analysis in multiple practices and has already seen an increase in the percentage of patients screened and the percentage of patients referred to FBHP.

2. Next Steps and Future Initiatives

a. Expand Data Sharing Process to Additional Practices

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CCHA intends to undertake several next steps to continue to build upon the success of these initial processes. As an early step, the data sharing and identification of where clients fall into the four-quadrant model will be a valuable tool in helping CCHA explore opportunities for improving care and outcomes for members. It is the goal of CCHA to assist PCMPs by showing them how enhanced care coordination and other interventions (such as warm handoffs to behavioral health practitioners in the co-located models) can be beneficial to their clients. This realization, backed by data which is shared in an appropriate HIPAA and 42 CFR compliant manner (including member consent and signed releases of information), will be helpful in encouraging primary care practices to take the next steps toward integration. As more primary care clinics begin to provide co-located physical and behavioral health services, and even more integrated services, the integrated data and stratification of members will be used by these practices and the behavioral health clinicians who are supporting integrated care at their clinics to ensure that all members are receiving appropriate care coordination and behavioral health services.

b. Make the Data Sharing Process an Ongoing Process

Once the processes are finalized and in place, and providers have begun to utilize the data to improve care, CCHA and FBHP will continue to do these data exchanges on a regular basis. CCHA and its behavioral health partners will continue to identify appropriate care coordination for these members, and will provide support to the primary care practices and behavioral health specialists as they work to provide these services.

c. Increase Utilization of Data

In addition, CCHA intends to continue to work with PCMPs to identify their current stage of integration and the opportunities for moving them along the continuum toward more integration and more advanced patient-centered medical homes. Other aspects of this shift are discussed elsewhere in this report. However, relative to this discussion about data sharing, CCHA will continue to work with practices *where they are now*, to help move them toward integration using this shared and comprehensive data set. For practices for which integration is very new and for which barriers seem particularly challenging, CCHA will create a completely de-identified set to demonstrate to these practices some of the opportunities for improved care and outcomes, and reduced cost, that can be realized with integration. For practices that have decided to move forward with this data exchange, but are still not sure about how to use the data, CCHA's Practice Coaches and FBHP staff will work with the practices to identify their concerns and work to overcome them. For practices that are ready to use the data, CCHA and FBHP will share best practices and information about interventions that may be useful moving forward. For practices that are already providing co-located care, CCHA and FBHP will work to identify barriers to a higher level of integration, and continue to provide updated shared data on a regular basis for ongoing use by the practices.

Over time, the goal is for CCHA, FBHP, the community mental health centers and the PCMPs to all have access to needed, relevant and appropriate date and information on mutual clients. This will support all entities as they will have a more complete picture of their patients' health status, service needs and care coordination needs and the providers will be able to help improve their patients' health and well-being.

d. Increase Development of Shared Care Management Plans and Clinical Notes

To facilitate more integrated care, primary care providers and behavioral health providers need to be able to create and share pertinent clinical information that is in keeping with federal law, and create shared care plans. Both sets of providers need to have access to these clinical notes and care plans, and need to use them to provide more coordinated care, including helping patients with medication management, management of chronic conditions, and understanding how their behavioral health issues may affect their physical health and vice versa. In addition to enhancing care, having access to shared electronic systems reduces duplication of record-keeping, including billing, and is, therefore, important to reducing barriers to implementing integrated care.

e. Support More Timely Access to SDAC Data

CCHA would like to work with the Department and the SDAC to develop a process to allow community mental health center partners and behavioral health organization partners to have more timely access to data, hopefully via direct access to the SDAC warehouse.

B. Innovations Related to Co-Location and Service Integration Activities

Although CCHA and FBHP provide services to individuals in five counties, the primary focus of co-location is in Jefferson, Boulder and Broomfield counties. This is because those counties – in particular Jefferson and Boulder – have the majority of Region 6 ACC Program enrollees who have either HCM eligibility or high behavioral health needs. CCHA is working closely with partners in those counties and has identified sites that:

- Are interested in co-location;
- Have a culture of practice transformation, including leadership in the form of an office manager and/or lead physician, to support the new approach; and
- Are large enough to support a co-located behavioral health practitioner that can serve Members with Medicaid, CHP+, Medicare and commercial insurance

CCHA and its partners intend to expand this co-location model as well as other models of integration to many more sites. As these initiatives evolve, the selection criteria will also evolve. For example, as best practices and strategies are implemented and working in some of the more sophisticated practices that have a culture of practice transformation the focus could shift to bringing on practices that will need more coaching and support.

1. Current Initiatives

a. Partnership with Mental Health Partners (MHP) in Boulder and Broomfield Counties

Currently, CCHA is working to identify practices that meet the criteria for co-location and are interested in having a behavioral health specialist located in their practice. Activities in these counties are taking a different trajectory because many ACC Program enrollees in these counties receive care from Salud Family Health Centers and/or Clinica Family Health Centers and not private providers. These FQHCs have excellent models of integration and rather than implementing a different model CCHA and FBHP will build off the extensive experience of these sites to work to expand integration ., Both Clinica and Salud will join the FBHP provider network (anticipated for late 2013) and will work with MHP and their own behavioral health staff. Their initiation of network provider status will allow members seen by Clinica or Salud to receive the full benefits of the community behavioral health program contracted to FBHP (to date there has not been reimbursement for the behavioral medicine services for Medicaid enrollees in the BHO contract).

b. Partnership with Jefferson Center for Mental Health (JCMH)

CCHA's partnership with JCMH reflects the PCMP enrollment of members, prevalence of HCM members and those with high behavioral health needs at the site(s) and takes advantage of the Union Square Health Home, a SAMHSA supported co-location site for JCMH, Metro Community Provider Network (MCPN) and Arapahoe House. As MCPN joins the FBHP provider network, just as Salud and Clinica will, the opportunity to document the benefit to Medicaid members for previously unbilled behavioral health services will support the expansion of integration. Unique opportunities to support the grant funded Advancing Care Together, a joint venture of MCPN, JCMH and Arapahoe House provides exceptional opportunity. With the expansion of substance

abuse service funding through FBHP and the practice establishment of this pilot project team that incorporates physical health, mental health and substance abuse, CCHA has a unique fully integrated site.

Initially, CCHA has identified four primary care practices in Jefferson County for co-location. As of September 30, 2013, identified PCMP sites include:

- Peak Pediatrics in Wheat Ridge
- Wheat Ridge Family Clinic in Wheat Ridge
- Lakewood Medical Center in Lakewood
- St Anthony Health Center in Evergreen

With the primary care providers identified and located in Jefferson County, CCHA and JCMH will utilize a model of co-location already in place. This model is being used with providers that are either not affiliated with CCHA or have contracts with CCHA but have very low numbers of ACC Program members attributed to them. The model has proven successful at integrating behavioral health into primary medical care (family practice and pediatric) and improving access and patient acceptance onsite at the medical practice. JCMH has placed behavioral health specialists in nine medical offices representing six practices:

- Altitude Family and Internal Medicine (Lakewood and Littleton) (has 18 CCHA attributed clients)[1]
- Belmar Family Medicine in Lakewood (in the process of signing the CCHA ACC Program contract)
- Conifer Mountain Family Medicine in Aspen Park (has 17 CCHA attributed clients)
- Family Care Southwest in Littleton (has 32 CCHA attributed clients)
- Lakewood Family Medicine in Lakewood
- Rocky Mountain Primary Care in Arvada in Lakewood and Westminster

In addition to the work with CCHA, JCMH continues to pursue additional practice sites that are interested in co-location.

Solutions Now

The program which is in place and will be implemented in additional primary care practices across Jefferson County is called *Solutions Now.* The practices that are currently using this model are transitioning to Patient Centered Medical Homes (PCMH) and are working towards higher levels of NCQA accreditation. Many practices are participants in federal grant initiatives such as the Comprehensive Primary Care Initiative. While not requirements or prerequisites, these activities do indicate a willingness and enthusiasm for practice transformation and a commitment to providing comprehensive, integrated care to patients. Participation in these

[1] Attribution numbers are as of September 30, 2013.

activities also provides good experience for practices in doing transformation work, and in building a culture that is supportive of transformation and is adaptable. Patients with all types of insurance served by the practice (and populations without insurance) can receive services; this is important both for financial sustainability and for practice transformation. However, the current behavioral health reimbursement landscape favors implementation of *Solutions Now* in practices with commercial and Medicare patients and not Medicaid patients.

CCHA is using the operational successes of *Solutions Now* to co-locate behavioral health providers in CCHA PCMP offices. The model has the following components:

- JCMH handles all credentialing and contracting with the major insurance plans and payers (there are rare exceptions to this).
- The patient is seen by a JCMH behavioral health provider who is responsible for obtaining reimbursement from the payer through JCMH's tax ID. There is no contractual or financial intermingling between JCMH and the medical practice but the care is seamless to the patients. Any co-pays are collected by the BH practitioner.
- Practice partnership extends to Jefferson Center services and specialties that can augment patient care and provide expert treatment and consultation for complex comorbid patients.
- There is regular communication between the primary care and behavioral health providers. This can be regularly scheduled meetings and/or more informal interactions.

Discussions with Primary Care Practices

To determine if the model, as proposed, is workable in a primary care practice and to assess interest in the approach, CCHA with HMA visited four primary care practices.

- Two sites have a co-located behavioral health specialist (Belmar Family Medicine in Lakewood and Family Care Southwest in Littleton).
- Two others are among those CCHA and FBHP identified for future sites (Peak Pediatrics and Lakewood Medical Center, both in Lakewood).

These discussions provided insight into any challenges or barriers (or in the case of future sites, perceived barriers) to co-location, opportunities for addressing these barriers, and next steps. Their comments and thoughts are detailed as follows:

- Overall perspective;
- Space needs;
- Scheduling
- Data and chart sharing;
- Reimbursement;
- Importance of relationships and attention to language and cultural needs;
- Practice readiness; and
- Next steps for the practice (future initiatives).

Overall Perspective

Three of the four practices were very enthusiastic about co-location; the two that have a co-located behavioral health provider had high praise for the multiple ways in which the co-located practice has been helpful to their patients. In addition, the practice has appreciated the opportunity to establish new relationships with other behavioral health providers and the behavioral health community. One of the future practices said they have been trying to figure out an approach for nearly eight years and had explored hiring someone on their own but found the process challenging. A practice that has had a co-located behavioral health practitioner for nearly two years said they too had explored hiring someone in-house but were not prepared for the credentialing and contracting that was required. This practice pursued co-location, in part to improve their "practice flow" and reduce wait times for patients. Having the ability to make a referral has helped them to stick to their schedules more effectively (behavioral health visits can be time-consuming for providers and would often extend past the end of the appointment; the behavioral health provider schedules longer appointments and is able to bill for them). Practices also like the ability to do a "warm hand-off" and make an immediate introduction for their patients. This can be especially valuable for those suffering from behavioral illness.

All of the practices said they have challenges with referrals to specialists (for example, making referrals for pediatric cardiology was identified as challenging) but that behavioral health referrals have been most difficult. In particular, it is difficult to find a psychiatrist. One of the identified future practices said medication management and access to a psychiatrist is their biggest behavioral health need.

Another practice with a co-located provider did caution that the increase in referrals and demand for psychiatric services has the potential to make scheduling even more difficult. There appears to be a shortage of psychiatrists for all patients, including those with commercial insurance. To address this identified need, JCMH is hiring a new psychiatric nurse practitioner for their clinic. JCMH anticipates this person will start on November 1, 2013.

Space Needs

Both the literature and the providers with indicate that finding space in a busy practice is one of the bigger challenges with this model. This can be especially problematic in pediatric offices where there might also be a need for a larger space to accommodate appointments with the family. Sites that have made co-location work often schedule behavioral health clinicians to be onsite on a day or days when not all providers are working and there is an empty exam room.

- One current site has a dedicated exam room (used two days a week by the behavioral health clinician) and places an additional chair which in the room during BH visits (the exam table is not used).
- Another site is using an exam room for behavioral health services, but has made it appear less "clinical". In addition to having two chairs (one of which is an arm chair), the room has flowers, a blanket to cover the exam table and softer lighting. A phone in the

room also enables the behavioral health practitioner to make follow-up phone calls and use any down-time more effectively.

- One of the new sites also said finding a space would be a challenge but not an insurmountable one given the importance they place on having a co-located behavioral health provider. This practice is embarking upon an expansion and re-design project; they have already worked with their architect to find and/or create a space. In the interim they will use an open exam room (made available when a practitioner is not in the office) or create a space in a file room.
- The fourth future site had concerns their exam room isn't large enough to accommodate behavioral health visits, though CCHA and JCMH representatives said exam rooms are often used.

Scheduling

The primary care practices handle the schedule for the co-located behavioral health provider. Depending upon the system, the practice either uses its own electronic scheduling system or a paper schedule. A paper schedule is used by the practice whose scheduling system is connected to their billing system. Neither primary care practice with a co-located BH provider indicated the scheduling was burdensome. One practice said they do in-person reminder calls for behavioral health appointments just as they do with the physical health appointments. This can be especially important for Medicaid patients with behavioral health needs since often they are struggling with multiple challenges (food security, employment, housing, etc.). Scheduling has not been a huge problem though one potential challenge (identified by a future site) is that the BH practitioner is not in the office every day so it could be difficult for patients to schedule a BH visit on the same day as a medical visit (to minimize trips to the office).

Data and Chart Sharing

The practices did not indicate that the inability to share information and medical/behavioral health records as well as access data in "real-time" were insurmountable challenges. Primary care providers acknowledged that "real-time" data would be the best option but they appreciated getting the pertinent and federally-compliant clinical information from the behavioral health practitioner within two days, which is much faster than current practice where there is no co-located behavioral health provider.

Reimbursement

One advantage to co-location as an integration strategy is that it doesn't require blending of funds or a new approach to provider payment. This makes it relatively easy to implement and, if necessary, to terminate the relationships if they are not working. That said, the continuation of the current funding model (fee-for-service for medical care and capitation for behavioral health care) does create some issues. For example, providers are not reimbursed for care coordination activities and for the discussions and collaboration that are essential to providing coordinated, integrated care and supporting primary care providers. In one practice, the team

meets at the end of the day on the two days the BH practitioner is on-site and this is time not reimbursed.

As described later, CCHA is interested in pursuing payments such as global payments or other approaches that will support providers (both primary care and behavioral health care) in coordinating care while bending the health care cost curve.

Importance of Relationships and Cultural Competency

The two co-located practices said that solid relationships are essential to successful collaboration, to coordinating care and to sustainability of the approach. The two co-located practices with whom we spoke said they were very satisfied with the co-located BH provider, trusted them and valued their contributions. They appreciated the opportunity to meet with the BH provider before the person was hired. One potential challenge with this approach is that if the co-located provider were to leave the program they would have to develop new relationships with the provider. That said, they indicated they trusted JCMH to select a replacement and didn't feel the transition would be overly disruptive for their patients. The primary care practices that have co-location also indicated that the improved relationships extend beyond the individual provider because they are also developing relationships with, and awareness of, other BH resources.

One of the future practices wondered about practitioners that speak Spanish and/or Vietnamese. JCMH is pursuing a bilingual English/Spanish provider but indicated it was unlikely they could find someone fluent in Vietnamese. JCMH does work regularly with the Asian Pacific Development Center and would pursue additional training, if needed and appropriate, for the BH provider located in that practice.

Practice Readiness

As stated earlier in this report, in order for the co-location model to work a practice must have a culture of practice transformation and be willing to share office space, invest in relationships, and address scheduling needs. In sum, the practice must be interested in and have the capacity to change the way they provide care to their patients. Though not a requirement, both co-located practices indicated that having gone through the PCMH accreditation process prepared them for their success in co-location, because they understood what it takes to do real transformation and to be patient-centered. Despite their investment in integration and their experience with transformation, the practices said they there was need for ongoing education and reminders to their providers to use the BH practitioner. This was true even among the two co-located practices which are embracing the medical home model and were excited about the co-location program. They said it took approximately four to six months to have their system "down."

Both current co-located practices said that peer learning is very helpful and is one way to support practices *where they are now* and help move them towards a medical home model and

increased integration practices. CCHA Practice Coaches and staff from the community mental health partners have worked with the practices to identify their concerns and work to overcome them, and should continue to do so with new practices as they begin to co-locate.

Next Steps and Transitioning to Further Integration

CCHA is excited about the practices already identified for co-location and will continue to bring on more practices in Jefferson, as well Boulder and Broomfield counties. In theory, a BH practitioner can be co-located within 30 days, depending on the pace at which the practice wants to move and identification of a BH provider. However, the reality is that the process does take longer and can take several months for the processes to be smooth, even for more sophisticated providers. CCHA intends to approach these types of practices as well as those that are not quite as "ready" but have a high volume of ACC Program members. CCHA has a growing portfolio of tools and services to meet the growing needs of patient centered medical homes and will employ these tactics to support providers and ensure more integrated care for ACC Program (and other) patients.

To support co-location wherever a practice is, CCHA will work with practices that piloted co-location with JCMH and facilitate peer learning and potential opportunities for mentoring. In addition, CCHA Practice Coaches will provide tools and support in the form of more regularly scheduled meetings, highlighting best practices and trouble-shooting on issues. One co-located practice indicated a desire to use the BH provider for group therapy services for their patients with chronic conditions that would benefit from behavior change therapy. CCHA is supportive of these activities and, with FBHP and the behavioral health partners, will provide assistance if needed in assessing best practices, thinking through any space needs, and helping develop quality metrics, if appropriate.

One provider in Massachusetts that has been co-locating behavioral health providers for many years said (on a SAMHSA sponsored webinar) that there is a need for ongoing motivational coaching to primary practice sites to remind them of the opportunity and to ensure any individuals new to the practice understand the value of having a BH provider on-site. With JCMH and other partners, CCHA will ensure this happens as necessary.

Moving forward, FBHP and CCHA will continue to discuss operational details of co-location with a particular focus, for example, on topics such as the role of the CCHA Care Manager and Practice Coach, role of the FBHP Care Manager, and relationships and expectations of co-located behaviorist and PCMPs.

Although co-location is a popular, quick way to introduce behavioral health into busy medical practices in order to serve their patients, CCHA views it as only the first step in a growing continuum of services and methods of using behavioral medicine to augment patient care. In taking this approach, moving further along the continuum of integration, and moving to the last of the levels of primary care/behavioral healthcare collaboration as proposed by Doherty,

McDaniel and Baird, in 1996 and later adapted by Heath and Wise Romero, it is likely that CCHA (and other RCCOs) will need to take on additional risk for care. These levels are [2]

Level 1– Minimal Collaboration: Behavioral health and other health care professionals work in separate facilities, have separate systems, and communicate about cases only rarely and under compelling circumstances.

Level 2 – Basic Collaboration at a Distance: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone, letters and increasingly through email. Providers view each other as resources but they operate in their own worlds, have little sharing responsibility, little understanding of each other's cultures, and there is little sharing of authority and responsibility

Level 3 – Basic Collaboration On- site with Minimal Integration: Mental health and other healthcare professionals have separate systems, but share facilities. They engage in regular communication about shared patients, mostly through phone, letters or email but the proximity supports at least occasional face-to- face meetings and communication improves and is more regular. They appreciate the importance of one another's roles and may have a sense of being part of a larger, though somewhat ill-defined team. This is the basic co-location model.

Level 4 – Close Collaboration On-Site in a Partly Integrated System: Behavioral health and other health care providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases and a basic understanding and appreciation for each other's roles and cultures. However, the pragmatics are still sometimes difficult, team-building meetings are held only occasionally and there are likely to be unresolved but manageable tensions over medical physicians' greater power and influence on the collaboration team.

Level 5 – Close Collaboration Approaching a Fully Integrated System: Behavioral health and other healthcare professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to the biopsychosocial/systems paradigm and have developed an in-depth understanding of each other's roles and cultures. Regular collaborative team meetings are held and there are conscious efforts to balance authority and influence among providers.

Level 6 – Full Collaboration ion a Transformed Fully Integrated Healthcare System: Providers have overcome barriers and limits imposed by traditional and historic service and funding structures. Antecedent system cultures and allegiances dissolve into a

[2] Adapted from the Collaborative Family Healthcare Association's (CFHA) Five Levels of Primary Care/Behavioral Healthcare Collaboration by William J. Doherty, Ph.D., Susan H. McDaniel, Ph.D., and Macaran A. Baird, M.D., and modified by Bern Heath, Ph.D. and Pam Wise Romero, Ph.D., Axis Health System, for the Colorado Integrated Care Learning Community.

single transformed system. Practice boundaries have also dissolved and care teams use newly evolved methodology to jointly assess, prioritize, and respond to patients' care needs. Providers and patients view the operation as a single health system treating the whole person. One fully integrated record is in use.

C. Delivery System Innovations – HCM Care Management Pilot

As described above, FBHP and CCHA are developing a HCM Care Management Pilot. As part of this pilot, these partners are developing an approach and methodology whereby some of the identified population (currently estimated at about 400 people) will receive their care coordination from the mental health clinic through its contract with FBHP. A financing mechanism will be developed to support their ability to provide these services since, for people with SMI, the mental health provider is the provider they see most often, is most aware of their needs (including medical, behavioral and social), and is most able to develop a comprehensive care plan, make edits as necessary and oversee their care.

As part of both this pilot and the evolution of the ACC Program, CCHA supports the mental health centers and FBHP in serving as PCMPs for patients such as those that will be in the pilot. Under this model, CCHA would not need to delegate the care coordination to them nor would it be necessary for CCHA to provide the funding. FBHP and the FQHCs are also working out details for their relationship when one of the enrollees in the pilot is attributed to an FQHC.

V. What data and outcomes should we use to measure progress?

CCHA has already begun collecting and tracking data to measure progress. CCHA recognizes that these measures (identified below) are primarily process measures and that everyone (CCHA, FBHP and HCPF) is interested in researching and evaluating client outcomes. However, improved physical and behavioral health outcomes, improved quality of life, and other measures such as increased employment rates or decreased homelessness rates are often not seen until several years after the intervention starts. It can also take several years to realize cost savings. Moving forward, CCHA and FBHP will develop quantitative, outcomes-based measures that are selected based on experience with co-location and integration as well as identified best practices.

To start, CCHA will track and trend the:

- Number of practices which have signed on to receive and utilize comprehensive shared data set;
- Number of practices who are utilizing the depression screening tool;
- Number of individuals screened using the depression screening tool, the number referred to behavioral health services, and the number who receive behavioral health services;
- Number of practices which have a co-located behavioral health provider on site, the number of hours the clinician is on site, the number of clients receiving behavioral health services and the number of hours of services delivered;

- Number of practices which have a shared care plan and shared clinical notes between behavioral health provider and physical health care provider; and
- Number of practices which have begun to utilize the behavioral health provider for additional services, such as behavior modification.

In addition to the quantitative process measures, CCHA is collecting qualitative data from the primary care clinic offices, and the behavioral health clinicians. The data will encompass: their perceptions of implementation; any challenges they are facing or have overcome; and their perceptions of changes in outcomes for patients and their clinical practice. All of these data will be used in an ongoing fashion by CCHA staff to provide additional practice transformation support, assist with implementation of co-location, and help new practices as they begin to co-locate.

VI. If the model Colorado plans to test is paying for integrated physical/behavioral health, what role can CCHA play in facilitating that integration or measuring its impact?

If the model that Colorado plans to test is paying for integrated physical/behavioral health, CCHA is well-positioned to play a role in facilitating that integration and measuring its impact. The roles that CCHA would play will depend in part on the strategy or strategies that Colorado embraces.

If Colorado is moving toward payment reform such as global payment pilots to test integration, CCHA could be a leader in implementing such a pilot and testing its effectiveness. CCHA already has the data sharing and utilization process developed and in place and could replicate that. Additionally, CCHA has a structure in place and experience providing coaching to practices and could utilize this structure to coach practices on changes in their billing and service delivery practices to test the impact of global payment on both quality and cost. CCHA could work with practices to help move them into more integrated stages, using their Practice Coaches, and supporting learning across practices. Should the State go this route, CCHA and FBHP could work together with the State to create a proposal for a global payment model and shared savings model that they would implement with practices, could facilitate and lead this implementation, and could share results and lessons learned back to the State and to other practices.

If Colorado intends to utilize the current payment structures (ACO managed FFS model with the behavioral health carve out and behavioral health capitation), by adding SIM-funded behavioral health integration work, CCHA could help the State with these efforts by continuing and building upon its already successful efforts. First, CCHA could continue its work of "meeting providers where they are" and implementing shared data and co-location as initial first steps for new practices. Second CCHA could continue to help practices that are already co-located move toward additional integration, sharing SIM funding with primary care practices and the BHO partner to help with start-up costs. Third, CCHA could share results of this work with the State and with other practices, and help

facilitate the implementation of similar strategies across the state, either via learning collaboratives or by providing technical assistance to primary care providers and behavioral health clinicians. Last, CCHA could implement “shadow billing” with providers who have implemented co-location, to begin to track costs and help provide a foundation for moving toward more integrated funding, and share findings with the State and providers. This approach has worked with other pilots and programs and provides valuable information to assess options to ensure financial stability in the absence of grant funding or capitation.

CCHA is also well-positioned to facilitate integration because of the solid foundation of established relationships. CCHA, FBH, the PCMPs, and the community mental health centers are working together already. Moreover, because the RCCO and BHO borders are the same, there are fewer relationships "to manage" which makes this region a great testing ground for innovation. Finally, because so much of the region is urban many of the practices are large and have a favorable payer-mix integration activities are possible and there are also fewer geographic barriers meaning that a BH provider could operate in multiple primary care practices.